

**CHILDREN & YOUTH FASD DIAGNOSTIC & SUPPORT TEAM**

% Child Development Centre  
P.O. Box 2703 Whitehorse, Yukon Y1A 2C6  
Phone: 867-456-8182 Fax: 867-393-6374

**REFERRAL FORM**

Name Child/Youth: \_\_\_\_\_ DOB: yy/mm/dd Gender: \_\_\_\_\_

Child/Youth lives with: \_\_\_\_\_

Relationship to Child/Youth:  Single Parent  Double Parent  Legal Guardian  Other \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Mailing Address:  Same as above or

P.O. Box/Street: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Preschool/Childcare Centre: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Person Making the Referral: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Relationship to Child/Youth: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Name of Social Worker: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This information is being collected for the purpose of assessing a child/youth's needs to determine programming and support. For further information, please direct inquires to the Coordinator, Children & Youth FASD Diagnostic & Support Team at 867-456-8182.

I would like to learn more about the assessment process. Consent for assessment will be obtained at a later date.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Signature of Person Making the Referral

\_\_\_\_\_  
Please print Name

\_\_\_\_\_  
Please print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date