

# FASD Services Spectrum Connections

Helping Manitobans living with FASD



## Referral, Eligibility & Assessment

Name of Individual:		Male <input type="checkbox"/>	Female <input type="checkbox"/>
(Surname)		(Given Names)	
Alias/AKA:		Height:	
SIN #:		Weight:	
Health #:		Identifying Marks:	
PHIN #:			
Current Living Situation (check applicable category)			
Foster <input type="checkbox"/>		Group Home <input type="checkbox"/>	
Emergency placement <input type="checkbox"/>		Homeless <input type="checkbox"/>	
Address:			
(City)		(Postal Code)	
Phone #		Hair Color:	
Age:	Date of Birth:	(YYYY/MM/DD)	
Place of Birth:		Eye Color:	
Aboriginal Status: Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Status Indian: Yes <input type="checkbox"/>		No <input type="checkbox"/>	
If yes band #	Treaty #	Email Address:	
EIA Worker:	Phone #		

CFS Involvement:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
CFS Agency:			
CFS Worker:	Phone #:		
CFS Authority:			
Permanent ward:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Extension of care:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
From:	To:		
(YYYY/MM/DD)	(YYYY/MM/DD)		
Voluntary Placement Agreement:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
From:	To:		
(YYYY/MM/DD)	(YYYY/MM/DD)		
Temporary Order:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other:			

**School Currently Attending:** \_\_\_\_\_  
**Last School Attended:** \_\_\_\_\_  
**Educational Level:** \_\_\_\_\_  
**Guidance Counselor:** \_\_\_\_\_  
**Resource Teacher:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Source of Income:** \_\_\_\_\_  
**Monthly Income amount:** \_\_\_\_\_  
**Employment and Income Assistance Worker:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_ **FAX #:** \_\_\_\_\_  
**SASH#:** \_\_\_\_\_

<b>MEDICAL AND MENTAL HEALTH</b>				
<b>Medical Diagnosis:</b>				
<b>(Diabetes, STI's, etc.)</b>				
<b>Medical Personnel involved:</b>				
<b>Name:</b>		<b>Phone:</b>		
<b>Name:</b>		<b>Phone:</b>		
<b>FASD Diagnosis: (Please attach assessment)</b>				
<b>ARND:</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Year:</b>	<b>(YYYY/MM/DD)</b>
<b>FAS:</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Year:</b>	<b>(YYYY/MM/DD)</b>
<b>pFAS:</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Year:</b>	<b>(YYYY/MM/DD)</b>
<b>Other:</b>				
<b>No Diagnosis within the fetal alcohol spectrum:</b>				
<b>Confirmed maternal drinking during the pregnancy?    Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>				
<b>Neurobehaviours consistent with ethanol exposure in utero</b>				
<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unknown</b> <input type="checkbox"/>				
<b>Co-morbidities (psychiatric) Diagnosed:</b>				
<b>Date:</b>		<b>Doctor:</b>		



## SUPPORT NETWORK

Name	Organization	Phone	Address

### Individuals Social Network (e.g. Extended family & those important to youth)

Name	Relationship	Phone	Address

### Family Involvement:

Name	Relationship	Phone	Address

***Please Describe the Individual:***

**Do you consider the youth high risk to self harm?                      Yes  No**

**Does the individual require supports to minimize the risk of self harm due to adaptive deficits? (e.g. extreme vulnerability, etc)                      Yes  No**

**Does the individual have behavior that indicates a fascination with fire or been involved in fire starting incidents?                      Yes  No**

**Does the individual require supports to minimize risk to cause physical violence?  
Yes  No**

**Does the individual require supports to minimize the risk of repeating sexually offending behavior? Yes  No**

**Has substance abuse caused any problems for the person: Yes  No**

**Explain:**

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**Describe Individuals Cultural Practices & Preferences:**

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**Is there an elder involved with the individual? Yes  No**

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

### **REFERRAL SOURCE**

**Name of organization/agency: (if applicable)** \_\_\_\_\_

**Worker:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**Relationship to youth/adult** \_\_\_\_\_ **Date of Referral:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Reason for Referral:**

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**(PLEASE INCLUDE RELEVANT INFORMATION FOR ANY / ALL OF THE ABOVE E.G PSYCH ASSESMENTS, CRIMINAL RECORDS, ETC.)**

**FAX THIS FORM TO THE FOLLOWING:**

**FASD Life's Journey Inc.**

**Program: Spectrum Connections FASD Services**

**Attention: Intake Review Committee**

**Fax #: 772-1784**

***For Office Use Only:***

SLP Eligible: Yes \_\_\_\_\_ NO \_\_\_\_\_

PSN Eligible Yes \_\_\_\_\_ No \_\_\_\_\_

CMH Eligible Yes \_\_\_\_\_ No \_\_\_\_\_

Service Category #: \_\_\_\_\_ Priority \_\_\_\_\_

Service required: \_\_\_\_\_

Level of service required: \_\_\_\_\_

Risk factors: \_\_\_\_\_

Recommendation re: eligibility: \_\_\_\_\_

Date for Intake Committee review: \_\_\_\_\_