Yellowhead Community Services Society
Referral Form - FASD
Fax/Email Completed Form: (see bottom of form)

Child's name: ______________________________ Gender: M F Date of birth (dd/mm/yyyy): _______________

Referral Source: ____________________________

Parent/care provider names(s) 1: ____

Home address: ____

Phone #: _________________________________ May we leave a text/message at this number? Yes No

Email: ____ May we email information to you? Yes No

Parent/care provider names(s) 2: ____

Home address: ____

Phone #: ____________________________________May we leave a text/message at this number? Yes No

Email: ____ May we email information to you? Yes No

Diagnosis (if known):

____

Does the child/family identify as Indigenous? Yes No Prefer not to answer

Reason for Referral:

____

Please provide any relevant medical background history & information:

____

Goals of Service:

____

Other Agencies/ Professionals involved with your family:

____

Signature of referral source: ____ Date: _____________________________

Referrals can be faxed or emailed to:

Program Manager: Robyn Lane
Phone: 250-674-2600 ext. 224
Fax: 250-674-2676
Email: Robyn.L@yellowheadcs.ca