PEDIATRIC AMBULATORY CLINIC FASD REFERRAL FORM

St. Michael's Health Centre
61 Queen Street East, 2nd floor
Toronto, ON M5C 2T2
T: 416-867-3655 | F: 416-867-3736

• (INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPELETION)
•Fax completed intake form to: (416) 867-3736
•We will contact your patient with appointment date and time
•Please note the booking process can take up to two weeks.
AVAILABLE ONLINE: unityhealth.to

REFERRAL DATE:

PATIENT INFORMATION	
MRN # ________________________ **Last Name:**________________________ ________________________ **First:** ________________________ ________________________ **D.O.B. dd/mm/yyyy:**______ **Age:**_______ **Address:** ________________________ ________________________ **City:** _________ **Prov:**_____ **Postal:**__________ **Phone# :** ________________________ **OHIP # :** ________________________ **IFH # :** ________________________ **OTHER INSURANCE #:** ________________________ **Legal Guardian :** ________________________ **Relationship :** ________________________ **Birth parent :** ________________________ **Adopted parent:** ________________________ **Guardian :** ________________________	**REFERRING PHYSICIAN** ________________________ Referring Physician (please print) / Billing # ________________________ Address ________________________ ________________________ Telephone #: ________________________ Fax # : ________________________ SIGNATURE Previously Seen in this clinic: Yes ◌ No ◌ Language Interpreter Required? □ NO □ YES – if yes language ________________________ American Sign Language Interpreter Required? □ NO □ YES

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Does the patient have a regular family doctor? □ NO □ YES
Confirmed Prenatal Alcohol Exposure: □ NO □ YES
Services involved:□ OT □ Speech and Language □ Psychology □

REASON FOR REFERRAL

We require:

- **ALL PERTINENT DIAGNOSTIC & LAB RESULTS**
- **LIST OF CURRENT MEDICATIONS**
- **INVESTIGATIONS**
- **ALL ASSESSMENTS (psychoed)**
- **GROWTH CHART**
- **PREVIOUS RESOURCES**