



**Lakeridge  
Health**

**Lakeridge Health FASD Diagnostic Clinic  
REFERRAL FORM**

**Date of Referral (DD/MM/YYYY):** \_\_\_\_\_

Child's legal guardian provided verbal/written consent to submit this referral

YES       NO (if no, referral will not be processed)

Child's name: \_\_\_\_\_  
Last Name      First Name      Middle Name      Date of Birth (DD/MM/YYYY)

Male     Female     Other    Health Card Number: \_\_\_\_\_ Version Code: \_\_\_\_\_

Address:

\_\_\_\_\_  
Unit #    Street #    Street Name    City    Postal Code

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_ Email: \_\_\_\_\_

Patient lives with:  Both parents     Mother     Father     Other – Specify: \_\_\_\_\_

Interpreter required for communication with parents/guardians  NO     YES – Language: \_\_\_\_\_

Parent/Guardian:

\_\_\_\_\_  
Last Name      First Name       Mother     Father     Other: \_\_\_\_\_

**Reason(s) for Referral:**

Suspected FASD (up to 18 years)

**Primary Concerns:**

**Medical History:**

Distribution: Chart

Please complete both pages

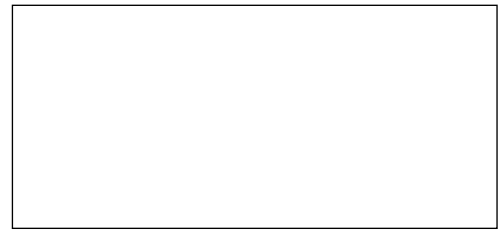
Page 1 of 2





**Lakeridge  
Health**

**Lakeridge Health  
FASD Diagnostic Clinic  
Referral Form**



**Primary Care Provider:** \_\_\_\_\_

**Referring Physician:**

Name: \_\_\_\_\_ Billing Number: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

**Physician Stamp/Address:**

**Fax to 905-721-7774**

FASD Diagnostic Clinic  
Lakeridge Health Oshawa  
1 Hospital Court  
Oshawa, ON  
L1G 2B9  
905-576-8711 ext. 36390



**Internal Use Only**

Date Received (DD/MM/YYYY): \_\_\_\_\_

Accepted by \_\_\_\_\_ On (DD/MM/YYYY): \_\_\_\_\_

More information required: \_\_\_\_\_

Physician contacted on (DD/MM/YYYY): \_\_\_\_\_

Declined – Reason:     Out of Catchment     Age     Reason for Referral

Other: \_\_\_\_\_

Physician notified on (DD/MM/YYYY): \_\_\_\_\_

