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/YYY)

☐ 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:

_____ _____ ☐ Mother ☐ Father ☐ Other: _____

Last Name First Name

Reason(s) for Referral:

☐ Suspected FASD (up to 18 years)

Primary Concerns:

Medical History:

Distribution: Chart

Please complete both pages

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): _____