



**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:**

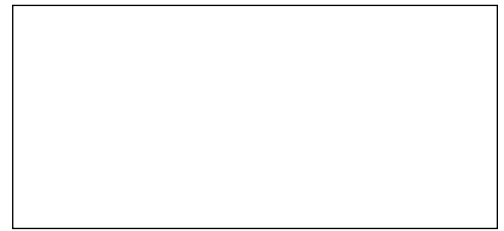
**Medical History:**





**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 905-721-4857**

FASD Diagnostic Clinic  
Lakeridge Health Oshawa  
1 Hospital Court  
Oshawa, ON  
L1G 2B9  
905-576-8711 ext. 33798



**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): \_\_\_\_\_

