Referral Form

Manitoba FASD Centre. Rehabilitation Centre for Children
633 Wellington Crescent. Winnipeg, MB R3M 0A8
. www.fasdmanitoba.com
Phone: (204) 235-8866. fax: (204) 235-8870

MANITOBA FASD CENTRE
• Assessment • Education • Training • Research •

Date of referral: _____ Source of Referral: _____

Child/Youth's Name: _____ Date of Birth: ___/___/___ d/m/y

Name of Caregiver: _____

Relationship to Child/Youth: ☐Birth ☐Adoptive ☐Foster ☐Other_____

Caregiver's Address:_____ City:_____

Postal Code:_____ Home Phone:_____ Work Phone:_____

Child/youth's physician: _____

Who is requesting this FASD assessment? _____

Is the child/youth's legal guardian in agreement with this referral? ☐Yes ☐ No ☐Unknown

If child/youth is 12 years of age or over, is he/she aware of this referral? ☐Yes ☐ No ☐Unknown

If no, would you like information on how to discuss this with him/her? ☐Yes ☐ No ☐Unknown

If the child/youth is in the care of a child welfare agency, please complete:

Name of Worker: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____ Email: _____

Is the child/youth in under a:

☐Permanent order ☐Temporary order ☐Voluntary placement agreement ☐ Voluntary surrender of guardianship
☐Other _____

Is the birth mother involved with the care of this child/youth? ☐Yes ☐ No Is she aware of this referral? ☐Yes ☐ No

PRESENTING PROBLEM

Briefly describe the child/youth's current difficulties. _____

_____

_____

_____

_____

_____

Has the child/youth received evaluation or treatment for the current problem or similar problem? ☐Yes ☐ No

If yes, when and with whom? _____

Is the child/youth on any medication at this time? ☐Yes ☐ No

If yes, list medications _____

What are the child/youth's strengths? _____

_____

_____

_____

Is the child in Daycare? ☐Yes ☐ No If yes, name of Daycare _____

Is the child/youth in school? ☐Yes ☐ No If yes, name of School _____ Grade_____

School Contact Person *[if known]* _____

FETAL ALCOHOL EXPOSURE HISTORY

In order for an assessment for FASD to occur, there needs to be prenatal alcohol exposure information. If the prenatal alcohol history is suspected and/or not available, please contact social work staff at the FASD Centre [(204) 235-8866] to discuss how to proceed with this referral.

Is the prenatal alcohol exposure confirmed? ☐Yes ☐ No Who is the source of this information? _____

Please provide information regarding prenatal alcohol exposure in this pregnancy *[if available]*. _____

_____

_____

_____

_____

Please provide information regarding other substance(s) which the child/youth may have been exposed to.

☐Tobacco ☐Solvent/Inhalant ☐Marijuana ☐Caffeine ☐Talwin & Ritalin ☐Cocaine ☐Crystal Meth

☐Other: _____

Name of person completing this form:_____

Relationship to child/youth referred:_____

Address *[if not provided above]* : _____ Phone: _____

Signature: _____ Date:_____

General Information Form

Manitoba FASD Centre. Rehabilitation Centre for Children
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Phone: (204) 235-8866. fax: (204) 235-8870

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Child/Youth's Name:_____ Date of Birth: ___/___/___ d/m/y

Age:_____ ☐Female ☐Male Health Care #:_____ PHIN#: _____

Name of Primary Caregiver: _____

Relationship to Child/Youth: ☐Birth ☐Adoptive ☐Foster ☐Other_____

Caregiver's Address:_____ City:_____

Postal Code:_____ Home Phone:_____ Work Phone:_____

Who is requesting the assessment at the Manitoba FASD Centre?_____

If other than legal guardian, has this request been discussed with the legal guardian? ☐Yes ☐No

What are the desired outcomes of the assessment? _____

_____

_____

_____

Describe the child or youth's current difficulties and how long they have been occurring._____

_____

_____

_____

_____

What are the child/youth's strengths? _____

_____

_____

_____

Has the child/youth been previously assessed for FASD? ☐Yes ☐ No ☐Unknown

If yes, diagnosis: _____ Who made the diagnosis?_____

Has the child/youth been seen at:

Child Development Clinic: ☐Yes ☐ No ☐Unknown If yes, when_____

Genetics: ☐Yes ☐ No ☐Unknown If yes, when_____

PROFESSIONALS INVOLVED

Child/Youth's Primary Physician(s) and/or Specialist(s): Include address, postal code and phone number *(if available)*.

Name _____ Name _____

Phone _____ Phone _____

Address _____ Address _____

Has a **psychologist, psychiatrist or mental health worker** assessed the child/youth due to mental health and/or behaviour concerns

☐Yes ☐ No ☐Unknown If yes, name of Assessor:_____ Date of Assessment: _____

Diagnosis/Outcome (e.g. Attention Deficit Hyperactivity disorder)_____

_____

Type of medication prescribed, if applicable: _____

Please forward summary of any above mental health reports to Manitoba FASD Centre.

SERVICES INVOLVED

Is the child/youth involved with any of these services?

Contact Information *Name/ Address /Email/ Phone*

- ☐ Child and Family Service _____
- ☐ Children's Special Services _____
  - ☐ Child Development Counsellor _____
  - ☐ FASD Outreach _____
- ☐ Children's Therapy Initiative _____
  - ☐ Audiologist _____
  - ☐ Occupational Therapist _____
  - ☐ Physiotherapist _____
  - ☐ Speech & Language Pathologist _____
- ☐ Mentor Program _____
- ☐ Respite _____
- ☐ School Support or Therapy Services _____
  - ☐ Child Guidance Clinic _____
  - ☐ Occupational Therapist _____
  - ☐ Physiotherapist _____
  - ☐ Psychology _____
  - ☐ Speech & Language Pathologist _____
  - ☐ Social Work _____
- ☐ Other support services _____

Please forward any/all reports to Manitoba FASD Centre.

FAMILY HISTORY

Birth Mother's Name:_____ Date of Birth: ___/___/___ d/m/y

Address:_____

Birth Father's Name:_____ Date of Birth: ___/___/___ d/m/y

Address: _____

Child/Youth's Brother(s) and/or Sister(s)			
NAME	Male/Female	Date of Birth (d/m/y)	Full or Half Sibling

Current Household Members: *(if siblings are also in this household, please circle their names above and their information does not need to be repeated below)*

NAME	Relationship to Child	Date of Birth (d/m/y)

Has anyone in this **child/youth's biological family** ever had any of the following conditions? *Please check all that apply.*

	Birth Mother	**Birth Father**	**Mother's Family**	**Father's Family**	**Siblings of child**
Learning Disability/Problems	____	____	____	____	____
Developmental Delays	____	____	____	____	____
Attention Deficit/Hyperactivity	____	____	____	____	____
Depression	____	____	____	____	____
Mental Illness	____	____	____	____	____
Chronic Illness	____	____	____	____	____
Emotional Problems	____	____	____	____	____
Speech & Language Delays	____	____	____	____	____
Birth Defects (cleft lip/palate, heart problems from birth)	____	____	____	____	____
Specific Genetic Syndrome	____	____	____	____	____
Others	____	____	____	____	____

Additional Information (Optional): _____

_____

_____

FETAL ALCOHOL EXPOSURE HISTORY

In order for an assessment for FASD to occur, there needs to be prenatal alcohol exposure information. If the prenatal alcohol history is suspected and/or not available, please contact social work staff at the FASD Centre [(204) 235-8866] to discuss how to proceed with this referral.

Was alcohol used in the pregnancy?	☐Yes	☐No	☐Suspected	☐Unknown
First Trimester (1 to 3 months)	☐Yes	☐No	☐Suspected	☐Unknown
Second Trimester (4 to 6 months)	☐Yes	☐No	☐Suspected	☐Unknown
Third Trimester (7 to 9 months)	☐Yes	☐No	☐Suspected	☐Unknown

Average number of drinks per drinking occasion: _____ Maximum number of drinks per occasion: _____

Number of drinking occasions per week: _____

Who is the source of this information? _____

If available, please provide additional information regarding the prenatal alcohol use and/or pregnancy.

_____

_____

_____

_____

If alcohol use is suspected but not known for sure, please describe reason for concern.

_____

_____

_____

Other exposures during this pregnancy:

Marijuana	☐Yes	☐No	Trimester_____
Cocaine	☐Yes	☐No	Trimester_____
Solvents	☐Yes	☐No	Trimester_____
Prescription Drugs	☐Yes	☐No	Trimester_____
Tobacco	☐Yes	☐No	Trimester_____
X-rays	☐Yes	☐No	Trimester_____

Other, please specify_____ Trimester_____

Have any siblings of this child/youth been diagnosed with FASD? ☐Yes ☐ No ☐Unknown

BIRTH HISTORY OF CHILD/YOUTH

Birth Hospital:_____ Address:_____

Was the child/youth born with, or later discovered to have any birth defects (e.g., cleft lip & palate, heart disease,)? ☐Yes ☐ No ☐Unknown

If yes, specify: _____

Was the child/youth premature? ☐Yes ☐ No ☐Unknown If yes, by how many week/months?_____

Did the child/youth have any of the following problems in the hospital? ☐Feeding ☐Apnea/breathing ☐Jaundice ☐Infection

MEDICAL HISTORY

Does the child/youth have any history of the following? If yes, please specify.

Chronic Illnesses: ☐Yes ☐ No ☐Unknown Explain:_____

Hearing Concerns: ☐Yes ☐ No ☐Unknown Explain:_____

Vision Concerns: ☐Yes ☐ No ☐Unknown Explain:_____

Hospitalizations: ☐Yes ☐ No ☐Unknown Explain:_____

History or Seizures: ☐Yes ☐ No ☐Unknown Explain:_____

Serious Accidents: ☐Yes ☐ No ☐Unknown Explain:_____

Is the child/youth currently on medication? ☐Yes ☐ No ☐Unknown If yes, please list *(e.g., Ritalin, Risperidone)*: _____

_____

DEVELOPMENTAL HISTORY *(if available)*

When did your **child/youth**.....

Sit with support Age_____
Crawl Age_____
Walk alone Age_____
Walk up stairs Age_____
Ride a tricycle using pedals Age_____
Use fingers to feed Age_____
Use a spoon Age_____
Feed self Age_____
Undress self Age_____

Dress self Age_____
Use zippers/buttons Age_____
Wash hands? Age_____
Become toilet trained (day) Age_____
Become toilet trained (night) Age_____
Say his/her first word Age_____
Put 2 words together Age_____
Use 3 to 4 word sentences Age_____

What percentage of language spoken in home is English? _____

Other languages spoken in the home? _____

Have you ever been worried about the child's development? ☐Yes ☐ No ☐Unknown

Has the child/youth ever had trouble with any of the following:

- ☐ Gross motor skills (use of large muscles for running, walking, climbing)
- ☐ Fine motor skills (use of hands, pencil skills)
- ☐ Language skills
- ☐ Self-control skills (impulse control, hyperactivity, attention span)
- ☐ Self-concept (child/youth's opinion about their appearance or abilities)
- ☐ Bedwetting or soiling
- ☐ Social skills (getting along with other children)
- ☐ Growth (Have you been concerned about your child/youth's growth?)
- ☐ Feeding (drinking, chewing or swallowing food)
- ☐ Sensory processing (reactions to noises, lights, touch, movement, tastes, smells)
- ☐ Sleeping (settling for sleep, sleeping through the night)

If you answered yes to any of the above, please describe:_____

_____

_____

DAYCARE / PRESCHOOL INFORMATION

Is your child attending daycare? ☐Yes ☐ No If yes, name of daycare: _____

Does your child/youth get extra help at daycare? ☐Yes ☐ No

SCHOOL INFORMATION

Is your child/youth attending school? ☐Yes ☐ No If yes, name of school: _____

School Division:_____

Is your child/youth having difficulty in school or daycare with (*check all that apply*)

☐ learning ☐behaviour ☐getting along with peers ☐sitting on the school bus
☐during lunch hour ☐during recess ☐in gym/music class ☐ before/after school

Does your child/youth get extra help at school from *(check all that apply)*

☐ level II funded ☐ level III funded ☐educational assistant ☐ resource time ☐other _____

Has your child/youth ever been suspended from school? ☐Yes ☐ No If yes, for what reason(s) _____

_____

_____

_____

(Please note: Further information from the school or daycare will be obtained through additional questionnaires.)

CHILD/YOUTH AND PARENTING INFORMATION

What are your child/youth's favourite activities? Least favourite? _____

_____

_____

Please describe your child/youth's behaviour, including any behaviours that may be challenging: _____

_____

_____

_____

_____

What disciplinary techniques or limit setting do you usually use with your child/youth? *Place a check next to each technique that you may use.*

☐Ignore problem behaviour ☐Reason with child/youth ☐Tell child/youth to sit on chair
☐Redirect child/youth's interest ☐Scold child/youth ☐Spank child
☐Take away some activity or food ☐Ground child/youth (For how long? _____) ☐Send child/youth to his/her room
☐Time-outs (For how long? _____) ☐Threaten child ☐Don't use any technique

[Optional] Please provide additional information _____

_____

_____

_____

Are you concerned about your child/youth using substances? ☐Yes ☐ No If yes, which: ☐Alcohol ☐Solvents/sniffing ☐Drugs

[Optional] Please provide additional information _____

_____

_____

ADDITIONAL FAMILY INFORMATION:

Has your child/youth experienced or witnessed any of the following: *[This can be left blank if child is in CFS care as similar history gathered in a Social History Form]*

- ☐ Upsetting losses or changes
- ☐ Family conflict/family stress
- ☐ Extended separations from mother and/or father or primary caregiver
- ☐ Other potentially stressful, upsetting and/or traumatic events

Please provide details if possible *(attach additional pages if needed)*_____

_____

_____

_____

_____

If the child/youth is in care of Child and Family Services, please complete the following:

Name of Authority: _____

Name of Agency: _____

Address: _____ Postal Code: _____

Name of Worker: _____

Phone: _____ Fax _____ Email: _____

Is the child/youth: ☐Temporary Ward ☐Permanent Ward ☐Under a Voluntary Placement Agreement

Is the birth family visiting with the child/youth? ☐Yes ☐ No

Is reunification with birth family planned? ☐Yes ☐ No

Is the birth mother aware of this referral? ☐Yes ☐ No ☐Unknown

Is the birth mother in agreement with this referral? ☐Yes ☐ No ☐Unknown

PERSON FILLING OUT THIS FORM

Name of person completing this form: _____

Relationship to the child/youth (or family): _____

Phone:_____ Address:_____

(include postal code)

Name of person providing the information *(if different from above)*:_____

Relationship to the child/youth (or family): _____

Phone:_____ Address:_____

(include postal code)

DATE COMPLETED_____

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Request for Social History Information

To be completed by: Child and Family Services Worker

633 Wellington Crescent
Winnipeg, MB R3M 0A8, Canada
Telephone: (204) 235-8866 Fax: (204) 235-8870

Date: _____

Child's Name: _____ Date of Birth: _____

Social Workers Name_____ Agency: _____

Phone Number:_____ Child's Legal Status:_____

Date of Child's recent admission to Agency Care:_____

Previous Admissions to Agency Care (if applicable):_____

Please describe the circumstances regarding the child's admission to CFS care. If applicable, please include information regarding any prior admissions to Agency care as well.

_____

_____

_____

_____

_____

_____

Is Reunification with the parent(s) currently being planned?_____

Is the birth mother aware of this referral to Manitoba FASD Centre? ☐ Yes ☐ No ☐ Unknown

Is she in agreement? ☐ Yes ☐ No ☐ Unknown

Please explain: _____

_____

_____

_____

Please provide information regarding this child's placement history (e.g. date child placed in present foster home;, number of previous placements and length of stay, reason for any past placement changes, child's reactions to moves and changes). If more space is needed please attach additional page (s).

_____

_____

_____

_____

_____

_____

Family Visits: (Please describe with whom the child visits, the visit frequency, are visits supervised? Are there any concerns regarding the visits?)

Has the child experienced or witnessed any of the following (Please circle):

☐ Physical abuse	☐ Sexual abuse	☐ Emotional abuse
☐ Emotional neglect	☐ Abandonment	☐ Family violence
☐ Multiple caregivers	☐ Sexualized behaviours	☐ Physical neglect
☐ High conflict custody and access situation	☐ Significant losses	☐ Other potentially traumatic events

Please provide details of any above concerns (unless details have already been provided in a previous section of this intake form). If extra space is needed please attach additional page (s):

Signature: _____

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Request for Daycare/Preschool Information

To be completed by: Daycare Director

633 Wellington Crescent
Winnipeg, MB R3M 0A8, Canada
Telephone: (204) 235-8866 Fax: (204) 235-8870

STUDENT'S NAME: _____ DATE OF BIRTH: _____

Parent/Guardian: _____ Address: _____

Postal Code: _____ Telephone No: (H)_____ (W)_____

DAYCARE INFORMATION:

Does this child currently attend a day care/preschool program? ☐ Yes ☐ No Number of days/week _____

Daycare/Nursery Program: Name _____

Address _____

_____
(include postal code)

Phone No.: _____ Fax No.: _____

Director: _____

When did the child start the program? _____

Special Needs Worker (one-on-one worker) ☐ Yes ☐ No

Type of Program: _____days/week Size of Program: _____

Please list any specific questions or concerns for which you would like help from the Manitoba FASD Centre with regards to this child.

_____

_____

_____

_____

_____

What are the child's strengths?

_____

_____

_____

_____

What are the child's weaknesses or difficulties?

_____

_____

_____

Describe the child's learning style (activity level, organization skills, impulsiveness, etc.)

_____

_____

_____

Please rate the child's ability in the following areas:

	Major Concern	Minor Concern	No Concern	Cannot Judge	Comment
GROSS MOTOR SKILLS					
• Posture	_____	_____	_____	_____	_____
• Gait	_____	_____	_____	_____	_____
• Fatigues Quickly	_____	_____	_____	_____	_____
• Tip-toe Walking	_____	_____	_____	_____	_____
• Ball Skills	_____	_____	_____	_____	_____
• Playground Safety	_____	_____	_____	_____	_____
• Playground Skills	_____	_____	_____	_____	_____
• Coordination	_____	_____	_____	_____	_____

Other (specify) _____

FINE MOTOR SKILLS					
• Crayon/pencil skills	_____	_____	_____	_____	_____
• Use of scissors	_____	_____	_____	_____	_____
• Printing/drawing	_____	_____	_____	_____	_____
• Hand Dominance	_____	_____	_____	_____	_____
• Switching hands	_____	_____	_____	_____	_____
• Puzzle skills	_____	_____	_____	_____	_____

Other (specify) _____

SELF HELP SKILLS					
• Undressing self	_____	_____	_____	_____	_____
• Dressing self	_____	_____	_____	_____	_____
• Use of zippers/buttons	_____	_____	_____	_____	_____
• Feeding self	_____	_____	_____	_____	_____
• Specify fork/spoon)	_____	_____	_____	_____	_____
• Washing hands/face	_____	_____	_____	_____	_____
• Helping clean up	_____	_____	_____	_____	_____
• Toileting	_____	_____	_____	_____	_____

Other (specify)_____

	Major Concern	Minor Concern	No Concern	Cannot Judge	Comment
BEHAVIOR & SOCIAL SKILLS					
• Ability to start play	_____	_____	_____	_____	_____
• Activity Level	_____	_____	_____	_____	_____
• Turn-taking	_____	_____	_____	_____	_____
• Abiding by rules & limits	_____	_____	_____	_____	_____
• Ability to share	_____	_____	_____	_____	_____
• Adjust to new routines	_____	_____	_____	_____	_____
• Attention span	_____	_____	_____	_____	_____
• Eye Contact	_____	_____	_____	_____	_____
• Ability to transition between activities	_____	_____	_____	_____	_____
• Solitary play	_____	_____	_____	_____	_____
• Resistance to go to day care	_____	_____	_____	_____	_____
• Frequent cries	_____	_____	_____	_____	_____
• Destructive of other's belongings	_____	_____	_____	_____	_____
• Physical aggression	_____	_____	_____	_____	_____
• Temper tantrums	_____	_____	_____	_____	_____

Other (specify) _____

SPEECH AND LANGUAGE SKILLS

• Speech Clarity	_____	_____	_____	_____	_____
• Understand Vocabulary	_____	_____	_____	_____	_____
• Understand Directions	_____	_____	_____	_____	_____
• Expressive Abilities	_____	_____	_____	_____	_____
• Initiate Conversations	_____	_____	_____	_____	_____
• Maintain Conversation	_____	_____	_____	_____	_____
• Terminate Conversations	_____	_____	_____	_____	_____
• Stuttering	_____	_____	_____	_____	_____

ENVIRONMENTAL:

Environment can impact on the behavior of a child. Please comment on the current daycare environment.

- Daycare is visually stimulating (i.e. decorations/displays on walls, hanging from ceiling)
  ☐ Yes ☐ No Comment_____
- Shelves are closed with doors or drapes to reduce stimulation.
  ☐ Yes ☐ No Comment_____
- Noise level in room is low; background noise is minimized or removed.
  ☐ Yes ☐ No Comment_____
- There is an area of the daycare that is private, secluded and free of stimulus where students are free to work or clam down, etc.
  ☐ Yes ☐ No Comment_____
- Open area classroom.
  ☐ Yes ☐ No Comment_____
- Fluorescent lighting.
  ☐ Yes ☐ No Comment_____

- Individual desk (If yes, location of desk).
  ☐ Yes ☐ No Comment_____

- Group seating.
  ☐ Yes ☐ No Comment_____

- Time out space for behavior management in classroom.
  ☐ Yes ☐ No Comment_____

- Calming space in classroom.
  ☐ Yes ☐ No Comment_____

How many transitions does the student encounter throughout the day? Please specify recess, lunch, and other classes.

_____

_____

How does the student handle these? Are any of the transitions particularly difficult?

_____

_____

_____

PERSON FILLING OUT THIS FORM:

Name of person completing this form: _____ Position/Title: _____

Referred by (e.g. who or what organization informed you about the centre?) _____

Signature: _____ Date: _____

Thank you for your help in completing this questionnaire. Please attach copies of the student's latest assessment or progress reports and include any other information, which may help for the assessment.

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Request for School Information

To be completed by: School Principal or Designate

633 Wellington Crescent
Winnipeg, MB R3M 0A8, Canada
Telephone: (204) 235-8866 Fax: (204) 235-8870

STUDENT'S NAME: _____ **Date of Birth:** _____

Parent/Guardian: _____ Address: _____

Postal Code: _____ Telephone No: _____

SCHOOL:
Name of School: _____ Principal: _____

Address: _____ Telephone No. Of School: _____

_____ Fax No: _____
(include postal code)

School Division: _____ Teacher's Name: _____

Case Manager: _____

STUDENT INFORMATION
Student's Grade Level or Placement: _____ Size of Class: _____ Date Enrolled: _____

Have any grades been repeated: ☐ Yes ☐ No ☐ Unknown If yes, what grade: _____

Please describe this student's present school placement:

☐	Regular Classroom	☐	Home Schooling	☐	Open Classroom
☐	Private School	☐	Combined Years Classroom	☐	Other _____
☐	Language Immersion (i.e. French)	☐	Bridging Year		

Does the student receive? ☐ Yes ☐ No In class resource help: _____ hrs per cycle.
☐ Yes ☐ No Out of class resource help: _____ hrs per cycle.

Name of Resource Teacher: _____ Other _____
(i.e.1:1 worker, teacher's aide, spec ed assist, etc.)

Does this student receive funding for assistance at school? ☐ Yes ☐ No
If yes, what level of funding? ☐ Level I ☐ Level II ☐ Level III Other: _____

Please list dates and attach scores or reports of any previous individual or group testing performed on this student:

- Achievement/Academic _____
- Hearing: _____
- Vision: _____
- Psychological/Psychometric _____
- Speech and Language _____
- Occupational Therapy _____
- Physiotherapy _____

NOTE: In order for a Manitoba FASD Centre assessment to proceed, psychology testing is required. If possible, psychology testing arranged through the school would be appreciated. If this is not available, please contact Manitoba FASD Centre to discuss other possible options. Thank you.

Which of the following services does the school provide and/or is currently received by this student:

	Available	Involved	Name/Address
• Behavior Specialist	_____	_____	_____
• Child Guidance Clinic	_____	_____	_____
• Community Health Nurse	_____	_____	_____
• Cultural Liaison Worker	_____	_____	_____
• Guidance Counsellor	_____	_____	_____
• Occupational Therapy	_____	_____	_____
• Physiotherapy	_____	_____	_____
• Psychology	_____	_____	_____
• Resource Program	_____	_____	_____
• Social Worker	_____	_____	_____
• Special Education Assistant	_____	_____	_____
• Speech and Language Pathology	_____	_____	_____
• Other (specify) _____	_____	_____	_____

Is this student currently receiving counselling in school? ☐ Yes ☐ No

Describe the student's learning style. (i.e. activity level, organizational skills, visual learner, kinesthetic learner, etc)

What are the student's strengths?

Does this student have any special interests or talents?

What are the student's weaknesses or difficulties?

Describe the student's social adjustment with other students. (i.e. Making friends, working in a group, aggression, withdrawal)

_____

_____

_____

Describe the student's social adjustment with adults. (i.e. Teachers, others)

_____

_____

_____

STUDENT PERFORMANCE

In each of the following areas, please rate the student's performance from your observation on a day-to-day basis:

	Major Concern	Minor Concern	No Concern	Advanced for age	Estimated grade level (if applicable)
Reading					
• Alphabet & Recognition	_____	_____	_____	_____	_____
• Alphabet Sound/Symbol	_____	_____	_____	_____	_____
• Instruction Reading Level	_____	_____	_____	_____	_____
• Reading Sight Vocabulary	_____	_____	_____	_____	_____
• Retelling/Comprehension	_____	_____	_____	_____	_____
Written Language					
• Is able to draw to represent ideas	_____	_____	_____	_____	_____
• Is able to write to represent ideas	_____	_____	_____	_____	_____
• Develop Level of Spelling	_____	_____	_____	_____	_____
Fine Motor Skills					
• Hand Dominance	_____	_____	_____	_____	_____
• Pencil Grasp	_____	_____	_____	_____	_____
• Colouring	_____	_____	_____	_____	_____
• Dexterity	_____	_____	_____	_____	_____
• Printing	_____	_____	_____	_____	_____
• Writing	_____	_____	_____	_____	_____
• Punctuation, legibility	_____	_____	_____	_____	_____
• Volume output/speed	_____	_____	_____	_____	_____
Arithmetic					
• Number Recognition	_____	_____	_____	_____	_____
• Rote Counting	_____	_____	_____	_____	_____
• Ability to track when counting (1:1 correspondence)	_____	_____	_____	_____	_____
• Basic Computation	_____	_____	_____	_____	_____
• Problem solving	_____	_____	_____	_____	_____

	Major Concern	Minor Concern	No Concern	Advanced for age	Estimated grade level (if applicable)
Language					
• Word Pronunciation					
• Comprehension of Verbal Instructions					
• Oral Sentence Structure/fluency					
Computer Skills					
• Keyboarding					
• Mouse Control					
• Word Processing					

Does the school have access to computers? ☐ Yes ☐ No

General knowledge					
Visual Memory					
• Short term					
• Long term					
Auditory Memory					
• Short term					
• Long term					
Gross Motor Skills					
• Balance					
• Ball Skills					
• Coordination					
• Sports					

Behavior & Social Skills					**Comment**
• Ability to start play					
• Activity					
• Turn-taking					
• Abiding by rules & limits					
• Ability to share					
• Adjust to new routines					
• Attention span					
• Eye Contact					
• Ability to transition between activities					
• Solitary play					
• Resistance to go to school					
• Frequent cries					
• Destructive of other's belongings					
• Physical aggression					
• Temper tantrums					

Other (specify) _____

ENVIRONMENTAL

Environment can impact on the behavior of a student. Please comment on the current classroom environment.

- Classroom is visually stimulating (i.e. decorations/displays on walls, hanging from ceiling)
  ☐ Yes ☐ No Comment_____
- Shelves are closed with doors or drapes to reduce stimulation.
  ☐ Yes ☐ No Comment_____
- Noise level in room is low; background noise is minimized or removed.
  ☐ Yes ☐ No Comment_____
- There is an area of the classroom that is private, secluded and free of stimulus where students are free to work or clam down, etc.
  ☐ Yes ☐ No Comment_____
- Open area classroom.
  ☐ Yes ☐ No Comment_____
- Fluorescent lighting.
  ☐ Yes ☐ No Comment_____
- Individual desk (If yes, location of desk).
  ☐ Yes ☐ No Comment_____
- Group seating.
  ☐ Yes ☐ No Comment_____
- Time out space for behavior management in classroom.
  ☐ Yes ☐ No Comment_____
- Calming space in classroom.
  ☐ Yes ☐ No Comment_____

How many transitions does the student encounter throughout the day? Please specify recess, lunch, and other classes.

_____

_____

How does the student handle these? Are any of the transitions particularly difficult?

_____

Is the child bused to school? ☐ Yes ☐ No _____

Other

School/Parent Relationship: Are parents aware/concerned? ☐ Yes ☐ No

_____

_____

Please list any specific questions or concerns for which you would like help from Manitoba FASD Centre with regards to this student.

Is there any other information the Manitoba FASD Centre should know about this student?

PERSON FILLING OUT THIS FORM

Name of person completing this form: _____ Position/Title: _____

Referred by (e.g. who or what organization informed you about the Centre?) _____

Signature: _____ Date: _____

Thank you for your help in completing this questionnaire. Please attach copies of the student's latest assessment or progress reports and include any other information, which may help for the assessment.

MANITOBA
FASD CENTRE
• Assessment • Education • Training • Research •

Authorization for Release of Information (Birth Records)

633 Wellington Crescent
Winnipeg, MB R3M 0A8, Canada
Telephone: (204) 235-8866 Fax: (204) 235-8870

I, _____ hereby authorize and direct
(Legal Guardian/Parent)

_____ to forward medical information regarding birth history/records received by:
(Hospital)

Name: _____ DOB: _____

MHSC#: _____ PHIN #: _____
(or alternate Health Care #)

Address: _____

Birth Mother: _____ DOB: _____

Birth Father: _____ DOB: _____

This information may be released to the
Manitoba FASD Centre
633 Wellington Crescent
Winnipeg, MB R3M 0A8
(For medical assessment purposes)

The _____ is hereby released from all legal liability that may arise from
(Hospital)

the release of the information requested.

Signature: _____ Date: _____

Print Name: _____

Witness: _____

Print Name: _____

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Consent/Authorization For Assessment

633 Wellington Crescent
Winnipeg, MB R3M 0A8, Canada
Telephone: (204) 235-8866 Fax: (204) 235-8870

I, _____, legal guardian, hereby, give the Clinic for Alcohol & Drug Exposed
(Please Print)

Children consent to assess, _____, date of birth _____
(Please print first and last name) M/D/Y

SIGNATURE: _____ _____
(Legal Guardian) (Print first and last name)

WITNESS: _____

DATE: _____

September 1, 2009