Juneau FASD Diagnostic Clinic
320 W. Willoughby Ave., Suite300
Juneau, Alaska 99801, 907-463-7373 * Fax 463-7343

REFERRAL FORM

Date: _____

Patient's Name: _____ _____
Last First Middle Initial Nickname

Date of Birth_____ Age_____

Caregiver's Name_____

Caregiver's Mailing Address _____

City_____ State_____ Zip Code_____

Phone_____ Cell_____ Email_____

Ethnicity _____
(American Indian, Alaska Native, Hispanic, Asian, Hawaiian, Other Pacific Islander, Caucasian, ,Other)
,
If Alaska Native, is he/she enrolled in the Tribe? □ Yes □ No □ Unknown

If yes, what Tribe? _____ Tribal Enrollment Number:_____

Is the person a beneficiary of IHS/SEARHC? □ Yes □ No □ Unknown

Name of Birth Parents_____

Person or agency that has legal custody:_____

Phone_____ Cell_____ Email_____

Name of person filling out this form:_____

Relationship to Patient:

□ birth parent □ grandparent □ legal guardian
□ adoptive parent □ other relative
□ foster parent □ Other (specify)

Phone_____ Cell_____ Email_____

Eligibility Criteria

1. A "high probability" of prenatal alcohol exposure must be well established.

2. The child should have at least one person who is a consistent advocate and is willing to accompany the child/adult to the clinic.

3. The parent, foster parent or legal guardian must complete with the assistance of our parent navigator a *New Client Information Packet and signed release of information* forms.

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History of prenatal alcohol use by the birth mother

Did the mother drink alcohol during her pregnancy? □ Yes □ No □ Unknown
Which trimester(s) did the mother drink alcohol? □ 1st □ 2nd □ 3rd □ Unknown

Was the mother ever reported to have a problem of alcohol? □ Yes □ No □ Unknown
Did the mother ever receive treatment of alcoholism? □ Yes □ No □ Unknown

If the history of prenatal alcohol use by the birth mother is not documented, please describe the mother's level of alcohol use before and during pregnancy to the best of your ability. _____

_____

_____

What concerns prompted you to make this referral? _____

_____

_____

_____

Does the person exhibit any of the following? (Check all that apply)

□ Hyperactive
□ Poor Attention
□ Immature
□ Poor Memory
□ Problems with learning
□ Not Organized
□ Impulsive
□ Sleep Problems
□ Other (list below)

Area of Concern

□ Physical health
□ Hearing
□ Vision
□ Growth ___ overweight ___ underweight
□ Height ___ short ___ tall
□ Diet and/or feedings
□ Sleeping

Area of Concern

□ Coordination and/or motor skills
□ Development of self-help skills
□ Speech/Language
□ Behavior
□ Discipline
□ Emotional adjustment

Reason for referral _____

_____

_____

_____

_____

_____

INSURANCE INFORMATION

Method of Payment:

□ Medicaid # _____ □ Denali Kid Care # _____

□ Insurance Company_____
□ Insurance Policy # _____
□ Insurance Company_____
□ Insurance Policy # _____
□ Other _____

Signature of person making referral for a minor
_____ Date _____

Signature of Adult Self Referral (required)_____ Date _____

Advocate for Adult Self Referrals _____

Please attach a signed and dated release of information with this referral. Thank you

Revised 10/26/10