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

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General Information Form For Child & Family Services Agency Workers

SSCY Centre — Specialized Services for Children & Youth

Date: _____

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

MHSC#: _____ PHIN#: _____ Gender: ☐ Female ☐ Male

Name of Caregiver: _____

Relationship to Child/Youth: ☐ Birth ☐ Adoptive ☐ Foster ☐ Other _____

Caregiver's Address: _____ City: _____

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

Who is requesting this FASD assessment? _____

Name of person completing this form: _____

Relationship to Child/Youth: _____

Phone: _____ Fax: _____ *Email:* _____

Who is the doctor providing medical care to the child/youth? _____

Child Welfare Agency Information:

Name of Worker/Legal Guardian: _____ *Phone:* _____

Agency: _____ *Fax:* _____

Email: _____

CFS Authority: ☐ *Northern* ☐ *Southern* ☐ *General* ☐ *Métis*

Legal status of child/youth: ☐ *Permanent order* ☐ *Temporary order* ☐ *Voluntary placement agreement*

☐ *Voluntary Surrender of Guardianship* ☐ Other _____

Describe the child/youth's current strengths and areas of interest:

_____

_____

_____

Describe the child/youth's current issues and concerns:

_____

_____

_____

Assessments

Has the child/youth been assessed by:

	Name of Clinician and Phone Number	Date (s) of Assessment	Report Attached &/or Currently Involved
☐ MB FASD Centre			☐ Report Attached ☐ Currently involved
☐ Child Development Clinic			☐ Report Attached ☐ Currently involved
☐ Genetics			☐ Report Attached ☐ Currently involved
☐ Occupational Therapist			☐ Report Attached ☐ Currently involved
☐ Physiotherapist			☐ Report Attached ☐ Currently involved
☐ Psychologist			☐ Report Attached ☐ Currently involved
☐ Psychiatry / Mental Health Worker			☐ Report Attached ☐ Currently involved
☐ Speech Language Pathologist			☐ Report Attached ☐ Currently involved
☐ Other			☐ Report Attached ☐ Currently involved

Are there any other services currently involved? _____

Developmental and/or Behavioral Concerns

Please describe current or past developmental or behavioral concerns:

Has the child/youth had difficulty with any of the following?

☐ Gross motor skills (use of large muscles like running, walking, climbing) _____
☐ Fine motor skills (use of hands and feet) _____
☐ Language skills (understanding instructions) _____
☐ Self control skills (impulse control, hyperactivity, attention span) _____
☐ Self concept (child's opinion about their appearance or abilities) _____
☐ Bed wetting or soiling _____
☐ Social skills (How your child gets along with other children?) _____
☐ Growth (Have you been concerned about your child's growth?) _____
☐ Feeding (Drinking, chewing or swallowing food)? _____
☐ Reactions to noise, lights, touch or movement? _____
☐ Sleeping (settling for sleep, sleeping through the night)? _____
☐ Alcohol and drug use _____
☐ Running away _____
☐ Self Harm (Cutting) _____
☐ Breaking the law _____
☐ Has the child/youth ever been exposed to trauma such as physical, emotional or sexual abuse or other stressful events?
____ yes ____ no

Briefly describe:

_____

_____

Medical History

Does the child have any history of the following? If so 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 of Seizures: ☐ Yes ☐ No ☐ Unknown Explain: _____

Does this child/youth have any other medical conditions? Please describe: _____

_____

_____

Does the child/youth have any other medical diagnoses? ☐ Yes ☐ No

If yes, please describe/list: _____

Is the child/youth currently being followed for the above condition(s)? ☐ Yes ☐ No

If yes, by whom: _____

Please list any medications that the child/youth is currently taking:

_____

_____

_____

Please list the child/youth's brothers and/or sisters:

_____

_____

_____

_____

Please list current household members:

_____

_____

_____

_____

Has anyone in this child/youth's birth family ever had any of the following?

Autism	☐ Yes	☐ No	☐ Unknown
Cerebral Palsy	☐ Yes	☐ No	☐ Unknown
Fetal Alcohol Spectrum Disorder (FASD)	☐ Yes	☐ No	☐ Unknown
Learning Disability	☐ Yes	☐ No	☐ Unknown
Developmental Delay	☐ Yes	☐ No	☐ Unknown
Hyperactivity	☐ Yes	☐ No	☐ Unknown
Mental Illness	☐ Yes	☐ No	☐ Unknown
Speech & Language Delays	☐ Yes	☐ No	☐ Unknown
Birth Defects	☐ Yes	☐ No	☐ Unknown
Specific Genetic Syndrome	☐ Yes	☐ No	☐ Unknown

Additional Information (optional): _____

_____

Prenatal History

Was alcohol used in the pregnancy?

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 occasion: _____ Maximum number of drinks per occasion: _____

Number of drinking occasions per week: _____

Who is the source of this information? _____

Comments: _____

_____

_____

Other exposures during this pregnancy

Marijuana	☐ Yes	☐ No	Cocaine	☐ Yes	☐ No
Solvents	☐ Yes	☐ No			

Prescription Drugs ☐ Yes ☐ No

Other, please specify: _____

Social History

Date of child's admission to Agency Care: _____

Please indicate reason for coming into 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.

_____

_____

_____

_____

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).

_____

_____

_____

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

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

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

- Is she in agreement? ☐ Yes ☐ No ☐ Unknown

Please explain: _____

_____

Family Visits: Please describe with whom the child visits and the visit frequency. Are there any concerns regarding the visits?)

_____

_____

_____

_____

Has the child experienced or witnessed any of the following:

□ Physical abuse	□ Sexual abuse	□ Emotional abuse
□ Emotional neglect	□ Abandonment	□ Family violence
□ Multiple caregivers	□ Sexualized behaviors	□ 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):

_____

_____

_____

_____

Consent of Legal Guardian for Assessment: □ Yes □ No

Name(s): _____ _____

Print Name(s): _____ _____

Thank you for completing this form.