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PIRUQATIGIIT
RESOURCE CENTRE

Piruqatigiit FASD Assessment Clinic

REFERRAL FORM

Date

Important Notes:
- This form is OPTIONAL.
- We accept Self-Referrals. Anyone can reach out to us to ask about being assessed. Please email us if you have any questions (clinic@piruqatigiit.ca).

Send the completed form to: clinic@piruqatigiit.ca OR drop off at 1089F Mivvik St, Iqaluit.

PERSONAL INFORMATION

Full Name

Preferred Name

Date Of Birth ____/____/____ **Gender** ☐ Male ☐ Female ☐ Other: ____

Address

Phone Number

Health Card # **NTI # (if applicable)**

CAREGIVER DETAILS

Full Name **Phone Number**

Relationship **Address**

E-Mail

Full Name **Phone Number**

Relationship **Address**

E-Mail

ACCESS NEEDS

Language Spoken at home **Would you like an interpreter/translator?**

☐ Yes ☐ No

Preferred Language

Additional accommodations needed at intake appointment (ex. sensory needs, physical space requirements)

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REFERRAL FORM

REFERRAL INFORMATION (IF APPLICABLE)

Name of Organization (if applicable) ____________________

Contact Person Name / Role ____________________

Relationship to child ____________________

Address ____________________

Phone Number ____________________

Email ____________________

Is the family aware you are sending this referral? ☐ Yes ☐ No

REASONS FOR REFERRAL

What do you know about this child/youth that leads you to believe they should be assessed for FASD?

Piruqatigiit Resource Centre
1089F Mivvik Street, Iqaluit
867-877-4155
www.piruqatigiit.ca
clinic@piruqatigiit.ca

INTERNAL USE ONLY

Date Received ____________________

Received by ____________________

Staff Signature ____________________