FASTRACK CLINICAL SERVICES

Fetal **A**lcohol **S**pectrum **T**raining, **R**esearch and **A**ssessment **C**linic for **K**ids

GP REFERRAL

REFERRER

Referrer:	Phone Number:
Organisation:	Fax:
Provider number:	Email:

CLIENT INFORMATION

Child's first name:	Child's middle name:	Child's surname:	
Preferred name:	Child's DOB:	Child's gender:	Medicare number:
Is this child Aboriginal? ☐ Yes ☐ No Is this child Torres Strait Islander? ☐ Yes ☐ No		Current day care or school attended:	

Is this child in the care of?

The CEO of the Department for Child Protection and Family Support (DCPFS)? ☐ Yes ☐ No

The Department of Corrective Services ☐ Yes ☐ No

CONTACT INFORMATION

Child's address:	Child lives with: ☐ Mother ☐ Father ☐ Carer	Child's birth hospital/location:

Mother's first name:	Mother's surname:	Mother's DOB:
Father's first name:	Father's surname:	Father's DOB:

Mother's phone numbers Home: Mobile:	Father's phone numbers Home: Mobile:
Carer's name:	Carer's phone number:
Email for primary contact person:	
Primary GP name / practice / phone number:	
Is an interpreter required? ☐ No ☐ Yes Which language?	

REASON FOR REFERRAL

Please tick all that apply:

- ☐ History of prenatal alcohol exposure
- ☐ Sibling with FASD diagnosis
- ☐ Physical features (facial anomalies or growth impairment)
- ☐ Learning difficulties
- ☐ Behavior or emotional concerns
- ☐ Neurological abnormality
- ☐ Association with Youth Justice

Please provide below a detailed description of each identified concern:

CLINICAL INFORMATION

Is this child registered with Disability Services Commission? ☐ Yes ☐ No
If yes, which one?

Date of last hearing test:
Please attach result if available

Has this child been seen by or referred to a psychologist? ☐ Yes ☐ No
Details:

Other current or previous health agencies involved with this child:

SUBMISSION

Has the Consent for Services and Sharing of Information form been signed? ☐Yes ☐No

Please send completed form with signed consent form via:

Email: fastrack@iinet.net.au
Fax: 9272 8549
Mail: FASTRACK Clinical Services
8 Walcott street,
Mt Lawley
WA 6050

Thank you for your referral. Please await contact from FASTRACK Clinical Services.
For more information, please email fastrack@iinet.net.au or call our clinic coordinator on 0499632692.

Office Use Only	*Date*
Referral Received	
Consent Signed	
Referrer contacted	
Client contacted	
Questionnaire complete	
Appointment booked for	
Final report compiled and sent	