CICADA FASD Service Referral Form

This form must be accompanied by a Paediatrician or other Specialist referral letter before it will be accepted.

PATIENT PERSONAL INFORMATION/ DEMOGRAPHICS

Surname			
Given Name(s)			
Gender	☐ Female	☐ Male	☐ Other
D.O.B			
Current Address			
Date this form completed			

Primary Caregiver Contact Details			
Primary Contact	☐ Biological Parents ☐ Foster/Kinship Carer ☐ Adopted Parents ☐ Other _____	Name	
		Address	
		Phone Number	
		Email	

Referrer Contact Details			
Referrer	☐ Paediatrician ☐ Psychiatrist ☐ Geneticist ☐ Other _____	Provider Number	
		Name	
		Address	
		Phone Number	
		Email	

Education Contact Details			
School/Childcare	☐ N/A *(e.g. Too young)* ☐ Childcare ☐ Primary School ☐ High School	School Year	
		Name of School	
		Phone Number	
		Email	

Who is the legal guardian? *(Name)*		
Has the legal guardian provided consent for this referral?	☐ Yes	☐ No

Does the individual you are referred identify as Aboriginal or Torres Strait Islander?		
☐ Aboriginal	☐ Torres Strait Islander	☐ Neither

PRENATAL ALCOHOL EXPOSURE

Only children with **confirmed** prenatal alcohol exposure will be offered an assessment

Was prenatal alcohol exposure:	☐ Confirmed Present
	☐ Unknown
What was the source of information about prenatal alcohol exposure?	☐ Biological Mother
	☐ Direct Witness
	☐ Official Records (Medical/Legal/Child Protection)
	☐ Other (Specify)
In your judgement, what is the reliability of the information about prenatal alcohol exposure?	☐ High
	☐ Low
	☐ Unknown

Alcohol Use in Pregnancy

Was the pregnancy planned or unplanned?	☐ Planned	☐ Unplanned	☐ Unknown
At what gestation did the birth mother realise that she was pregnant?	_____ (weeks)		☐ Unknown
Did the birth mother drink alcohol before the pregnancy was confirmed?	☐ Yes	☐ No	☐ Unknown
Did the birth mother modify her drinking behaviour on confirmation of pregnancy?	☐ Yes	☐ No	☐ Unknown
	If yes please specify:		
During which trimesters was alcohol consumed?	☐ 0	☐ 1st	☐ 2nd	☐ 3rd	☐ Unknown

The diagnosis of FASD requires confirmation of PAE. Please complete the follwing if the information is available from the biological mother or a reliable source

1. How often did the birth mother have a drink containing alcohol during this pregnancy?

☐ Unknown	☐ Never (0)	Monthly or less ☐ (1)	☐ 2-4 times a month (2)	2-3 times a week ☐ (3)	4 or more times a ☐ week (4)

2. How many standard drinks did the mother have on a typical day when she was drinking during the pregnancy?

☐ Unknown	☐ 1 or 2 (0)	☐ 3 or 4 (1)	☐ 5 or 6 (2)	☐ 7 to 9 (3)	☐ 10 or more (4)

3. How often did the birth mother have 5 or more standard drinks on one (1) occasion during this pregnancy?

☐ Unknown	☐ Never (0)	Less than monthly ☐ (1)	☐ Monthly (2)	☐ Weekly (3)	☐ Daily or almost daily (4)

What is the total AUDIT-C Score?	
Is there evidence that the birth mother ever had a problem associated with alcohol misuse or dependency?	
☐ Yes	☐ Alcohol dependency *(Specify) Source:*
	☐ Alcohol-related injury *(Specify) Source:*
	☐ Alcohol-related illness or hospitalisation *(Specify) Source:*
	☐ Alcohol-related offence *(Specify) Source:*
	☐ Other *(Specify) Source:*
☐ No	
Is there evidence that the birth mother's partner has ever had a problem associated with alcohol misuse of dependency?	
☐ Yes	*Source*
☐ No	

Please *attach* any additional information regarding evidence of alcohol use during pregnancy

Sentinel Facial Features

In a small proportion of cases, the diagnosis may be considered in the absence of documented Prenatal Alcohol Exposure (PAE). Please indicate whether, from your clinical examination, the child has any of the 3 sentinel facial features of FASD:

- ☐ Thin Upper Lip
- ☐ Flat Philtrum
- ☐ Short Palpebral Fissure

Does the child have:

- ☐ Microcephaly

  If yes, please indicate head circumference _____ and percentile _____

Are there any other comments or concerns that you would like us to know about?

Please return all correspondence to:

- **Mail:** CICADA FASD Service, Dept of Adolescent Medicine, Locked Bag 4001, WESTMEAD NSW 2145
- **Email:** SCHN-CICADA@health.nsw.gov.au
- **Fax:** (02) 98452517

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Date Referral Received			
Date Referral Accepted			
Entered On To Tracking Sheet	☐ Yes	☐ No	
Triage Level	☐ Triage 1	☐ Triage 2	☐ Triage 3
Initial Assessment Booking	☐ Face To Face	☐ Telehealth	
Date of Initial Assessment			

CHW MRN (If known)	