



CASS CAPA Referral Form

Referral Source Information

Referral Source: _____ Referral Date: (YYYY-MM-DD) _____

Organization: _____ Contact Number: _____

Email: _____

Relationship to Individual: _____

Will the referral source be able to attend an interview? Yes No

Is Individual aware of referral? Yes No

Individual's Demographics

Name: _____ Date of Birth: (YYYY-MM-DD) _____

Address: _____

Cell Number: _____ Home Number: _____

Email: _____

Source of Income: _____

Trustee/Guardian: _____ Phone Number: _____

Emergency Contact: _____

Medical Information

Reason for referral:

Does the Individual have an FASD diagnosis? Yes No

Diagnosis/Health Concerns:

Is it possible to have access to previous assessments? Yes No

Who completed the diagnosis? _____ Date: (YYYY-MM-DD) _____

Where? _____

Other Information

Educational History (last year of school completed, which programs participated in, etc.):

Work History:

Does the individual have dependent children? (If yes please state how many) Yes No Number: _____

Any other information of importance:

Important People

Contact Person / Role: _____

Agency: _____ Contact #: _____

Contact Person / Role: _____

Agency: _____ Contact #: _____

Contact Person / Role: _____

Agency: _____ Contact #: _____

PLEASE NOTE: Once this form has been completed please email it to capa.intake@c-a-s-s.org, fax to 403-283-0691, or deliver in person to our office. If there are any questions please call 403-283-0611. Someone from CAPA will be in contact with you shortly once this form has been received.