Métis Nation of Alberta

Department of Children and Family Services

BRIDGING CONNECTIONS: FETAL ALCOHOL SPECTRUM DISORDER PROGRAM INTAKE FORM

Client Information

Name: (First, middle, last): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Gender: _____ Cell Phone: _____ Home Phone: _____

Email: _____ Date of Birth (yyyy/mm/dd): _____

MNA Region: _____

Métis Standing: ☐ Self-Identify ☐ MNA Citizen ☐ Registration in Progress ☐ N/A

Does the client have FASD or is the client suspected of having FASD? ☐ Yes ☐ No ☐ Unknown

If yes, does the client have an FASD diagnosis? ☐ Yes ☐ No ☐ Unknown

Parent / Guardian Information (if applicable)

Please include all parent/guardian names:

Name: (First, middle, last) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Relationship to Client (parent, legal guardian, foster, kinship, etc.):

Additional Information:

Parent / Guardian Information

Name: (First, middle, last) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Relationship to Client (parent, legal guardian, foster, kinship, etc.):

Additional Information:

Community Supports Information:

Please provide us with current support person/agency contact information.

Please include all support persons, if applicable.

Organization Name (if applicable): _____

Support Person Name/Role (First and last): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Relationship to Client (parent, legal guardian, foster, kinship, etc.):

Community Supports Information:

Organization Name (if applicable): _____

Support Person Name/Role (First and last): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Relationship to Client (parent, legal guardian, foster, kinship, etc.):

Additional Notes:

Completed by: _____ Date:_____