



Hawai'i Community Genetics
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FETAL ALCOHOL SPECTRUM DISORDER (FASD)
DIAGNOSTIC CLINIC REFERRAL FORM

Date _____

Patient name _____ DOB _____

Insurance _____ ID # _____

Subscriber _____

Parent/Guardian (Circle one to indicate relationship to child)

Name _____

Address _____
Street Address Apt. # City ZIP

Phone _____ Alternate phone/cell _____

Primary Care Provider _____ Phone _____

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

____ Known or suspected prenatal alcohol exposure

____ Physical features consistent with FAS

____ Developmental delay/Cognitive impairment

Referral source/Agency _____

Contact Name _____ Phone _____