Eastern Health

Direct Home Services Program

Intervention Services
Autism Referral (Part I)

Office Use Only:

File: _____

CRMS: _____

Zone: _____

PLEASE PRINT CLEARLY:

Date of Referral (DD/MONTH/YYYY)	Child's First Name, Middle and Last Name:	HCN:

Address: _____ City: _____ Postal Code: _____	Male □ Female □	Date of Birth: (DD/MONTH/YYYY) _____

Is child attending school:

☐ Not Applicable ☐ Delayed Kindergarten ☐ Kindergarten ☐ Grade One ☐ Grade Two ☐ Grade Three

Living Arrangement: _____	Has Parent/Legal Guardian consented to this referral? □ Yes □ No Please note: Parent/Legal Guardian's permission is required

Parent(s)/Legal Guardian's name and relationship to child:

Name: _____ Date of Birth (DD/MONTH/YYYY): _____ Relationship: _____

Address: □ Same as above _____

Name: _____ Date of Birth (DD/MONTH/YYYY): _____ Relationship: _____

Address: □ Same as above _____

Telephone Number(s):

Home: Cell: Work: Can voicemail be left? ☐ Yes ☐ No

Children, Seniors, Social Development Involvement:

Social Worker: _____

☐ Not Applicable

☐ Currently

Telephone:_____

Diagnosis:	Date of diagnosis (DD/MONTH/YYYY):	Diagnosis location:

Assessments completed:	Assessor/title:	Report attached: ☐ Yes ☐ No

Referral Source name:	Referral Source job title:	Referral Source signature:	Referral Source telephone:

The personal information is being collected under the authority of Sections 29, 30 and 31 of the Personal Health Information Act and will be used for the purpose of planning your care. If you have questions concerning the collection, use, and disclosure of this information, please contact Intervention Services. If you have questions relating to Privacy and Access, please contact 777-8025.

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Direct Home Services Program

Intervention Services
Autism Referral (Part II)

Name:

HCN:

Date of Birth:

List referrals made to other services and date (DD/MONTH/YYYY):	Other Professional(s) involved and Telephone Number(s):
_____	_____
_____	_____
_____	_____
Additional Diagnosis/es (if applicable):	
Additional Comments:	

Fax To: Intake - Autism Services Eastern Urban at 709-752-4580 or Eastern Rural at 709-466-6404
For inquiries phone: Eastern Urban at 709-752-4188 or Eastern Rural at 709-466-5719

Referral Source Name: _____ Signature: _____ Date: _____DD/MONTH/YYYY_____

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