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:

☐ Not Applicable
☐ Currently

Social Worker: ________________

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.

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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