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| **Referral to**  **Ontario Autism Program** | | | | | | | | | | | **Referral Source** | | | **Parent** | | | | | | **Other**  **(please fill in below)** | | | | | | |
| Organization | | |  | | | | | | | | | | | | |
| **Date of this Referral Form (dd/mm/yyyy)** | | | | | | | | | | | Name | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | Phone | | |  | | | | | | | | | | | | |
| **What region do you live in?** | | | | |  | | Hastings, Prince Edward | | | | | | | Kingston, Frontenac, Lennox & Addington | | | | | | | | Lanark, Leeds & Grenville | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section A: Individual Child/Youth** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name | | | | | | | | First Name | | | | | | | | | Date of Birth (dd/mm/yyyy) | | | | Gender | | | | | |
|  | | | | | | | |  | | | | | | | | |  | | | | Male | | | Female | | |
| Address | | | | | | | | City | | | | | | | | | | Province | | | | | | Postal Code | | |
|  | | | | | | | |  | | | | | | | | | |  | | | | | |  | | |
| **Section B: Parent(s)/ Legal Guardian** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name | | | | | First Name | | | | | | | | | | | | Address **(if different from child)** | | | | | | | | Aware of Referral | |
|  | | | | |  | | | | | | | | | | | |  | | | | | | | | Yes | No |
| Home Phone | Cell Phone | | | | | | | | | Work Phone | | | | | | | E-mail | | | | | | | | | |
|  |  | | | | | | | | |  | | | | | | |  | | | | | | | | | |
| Last Name | | | | | First Name | | | | | | | | | | | | Address **(if different from child)** | | | | | | | | Aware of Referral | |
|  | | | | |  | | | | | | | | | | | |  | | | | | | | | Yes | No |
| Home Phone | | Cell Phone | | | | | | | | | | Work Phone | | | | | E-mail | | | | | | | | | |
|  | |  | | | | | | | | | |  | | | | |  | | | | | | | | | |
| **Section C: Alternative Contact** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name | | | | | | First Name | | | | | | | | | | | Telephone Number | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| **Section D: Custody** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there shared custody? | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section E: List Relevant Reports Attached** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Report Name | | | | | | | | | | | | | | | Agency | | | | | | | | | | | |
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| **Ontario Autism Program “OAP”** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Who can refer?** | | | **Parents, legal guardians** and **designated professionals** (for example, Family Physicians, Pediatrician and or Developmental Pediatrician, Psychologists, Psychological Associates, Psychiatrists, Speech Language Pathologists, Occupational Therapists, Registered Social Workers, Board Certified Behaviour Analysts, and Nurses (includes Registered Practical Nurses, Nurses and Nurse Practitioners) and Early Interventionist/Infant Development Worker) with the family’s consent. | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Criterion** | | | All children and youth from 0-18 years of age, with a written diagnosis of ASD from a qualified professional, are eligible for services in the Ontario Autism Program (OAP). | | | | | | | | | | | | | | | | | | | | | | | |
| * **Please provide a report or letter**from the diagnosticianwhichclearly states that the child has an Autism Spectrum Disorder   **Note: The child will be placed on the OAP waitlist once a written diagnosis is provided.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Our phone number is: 1-844-855-8340 for Autism Services** **in the South East Region** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **You may also fax, email or mail your referral to the appropriate region below** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hastings, Prince Edward | | | | | | | | | Kingston, Frontenac, Lennox & Addington | | | | | | | | | | Lanark, Leeds & Grenville | | | | | | | |
| **Counselling Services of Belleville & District**  12 Moira Street East  Belleville, ON K8P 2R9  Phone: 613-966-7413  Fax: 613-966-2357  Email: tracey.corrigall@csbd.on.ca | | | | | | | | | **Pathways for Children and Youth**  31 Hyperion Court  Kingston, ON K7K 7G3  Phone: 613-546-8535 Ext. 1  Fax: 613-546-0623  Email: intake@pathwayschildrenyouth.org | | | | | | | | | | **Lanark Community Programs**  30 Bennett Street  Carleton Place, ON K7C 4J9  Phone: 613-257-7619 Ext. 3242  Fax: 613-257-2675  Toll Free: 1-866-257-7618  Email: hballinger@lcp-home.com | | | | | | | |
| For more information about the new Ontario Autism Program, please visit the MCYS website at:  <http://www.children.gov.on.ca/htdocs/English/specialneeds/autism/ontario-autism-program.aspx> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Intake Administrative Use Only** | | | | | | | | | | | | | **Client ID#** | | | | | | | | | | | | | |
| Date of First Contact (m/d/y) | | | | Date Referral Form Received (m/d/y) | | | | | | | | | | | | Date Documentation Received (m/d/y) | | | | | | | Reports Attached | | | |
|  | | | |  | | | | | | | | | | | |  | | | | | | | Yes  No | | | |