**CSBD/QCTC Multidisciplinary Clinic**

**Appointment Application form**

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| **Date** |  | | | **Parent/Guardian** | | |  | | | | | |
| **Child Name** |  | | | **D.O.B.** | |  | | | | | | |
| **Address** |  | | | **City** | |  | | **Postal Code** | | |  | |
| **Phone** |  | | | **Email** | |  | | | | | | |
| **What behaviour/skill would you like addressed in your appointment?**  **\*Please note -** significant aggression or self-injurious behaviour cannot be addressed during this clinic appointment as it requires more rigorous assessment to adequately address. This service is not a crisis service, and focusses on skill building. | | | | | | | | | | | | |
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| **Preferred appointment location:** | | | | | | | | | | | | |
| Belleville | | | Madoc | | Picton | | | | Trenton | | | |
| **Preferred appointment time:** (Appointments will be scheduled between 10:15 and 5:00pm) | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Request to meet with:** | | | | | | | | | | | | |
| ABA Therapist | | | OT | | SLP | | | |  | | | |
| **In order to be eligible for an appointment, your child/youth:**   * Must be registered under OAP. * Must have **one** identify goal area. * Agree to a mediator model with parent-led implementation. | | | | | | | | | | | | |
| **Please answer the following questions:** | | | | | | | | | | | | |
| My child is receiving other services. | | | | | | | | | | Yes | | No |
| If yes, where? | |  | | | | | | | | | | |
| My child is on the waitlist for other services. | | | | | | | | | | Yes | | No |
| If yes, where? | |  | | | | | | | | | | |
| My child has received services for this skill/behaviour in the past. | | | | | | | | | | Yes | | No |
| If yes, what service? | |  | | | | | | | | | | |
| Should a follow up appointment be required, are you interested in a virtual appointment? | | | | | | | | | | Yes | | No |