**CSBD/QCTC Multidisciplinary Clinic**

**Appointment Application form**

|  |  |  |  |
| --- | --- | --- | --- |
| **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. |
|  |
| **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 |