Date of Referral: _______________

Autism Services Referral Form

Name: ____ DOB: ___________________

Address: ____ HSN: ___________________

Phone: ____________________/___________________ Gender: ______________________

Parent(s)/Guardian(s):____

Who does this child live with? _______________________ School: _____________________

Diagnoses (if applicable): ____

Diagnosed by: ____

Current Services Used (e.g., School Supports, Doctors, Therapies, ECIP, CLSD, ABCD):

____

____

Areas of Concern:

☐ Communication (e.g. understanding & using language):

____

☐ Social Skills (e.g. playing & relating with others):

____

☐ Regulation (e.g. coping skills, ability to calm self, understanding/recognizing emotions):

____

☐ Activities of Daily Living (e.g. toileting, dressing, bathing, eating, sleeping):

____

☐ Other: ____

Referral made by: ______________________ Phone: _______________________

Relationship to child: ____

Informed Parental Consent (signature or verbal): ____________________________________

Mental Health, Victoria Square
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Prince Albert, SK S6V 6G1
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