

Enhanced Psychological Services for Adults with Autism Spectrum Disorders Referral for Direct Client-Related Services

Mail or Fax Completed Form, Attention Deb Hay, Fax: (306) 665-7014

Please contact Dr. Deb Hay if you are unsure about what services would be most appropriate for this client. It can then be discussed what might be most helpful and the information needed to ensure satisfactory service

Contact: Deb Hay email: adultpsych@autismservices.ca or (306) 249-4472.

CLIENT INFORMATION

Client's Legal Name		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Mailing Address			
No & Street or Box No.	City	Prov	Postal Code
Date of Birth <small style="text-align: center;">DD/MM/YY</small>	Home Ph:	Work Ph:	
Email:		Cell Ph:	
Living Situation: <input type="checkbox"/> Lives Family of Origin <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Roommates <input type="checkbox"/> Supported Living or Group Home <input type="checkbox"/> Lives with Spouse and/or Children		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married or Common-in-law <input type="checkbox"/> Separated or Divorced	
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Supported Work Placement (Specify): _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> High School <input type="checkbox"/> Vocational or Post Secondary Training (Specify): _____ <input type="checkbox"/> Disability <input type="checkbox"/> Social Assistance			

Client is aware of the referral: Yes No

Appointment to be made:

with the client directly through Health Region ASD Consultant or other involved professional making referral

REFERRAL INFORMATION

Health Region referred by:	Contact person:
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Role & area of service: (eg. Psychologist, Mental Health)	Phone number: Email:
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Mailing Address

No & Street or Box No.	City	Prov	Postal Code
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Reason for Referral: *What are the major concerns. What do you and/or the client hope to gain from the service.*

Please list other professionals involved:

Name	Profession/Agency	Mailing Address	Phone/Email	Date last seen

SERVICE REQUESTED

Please check the appropriate service request and circle all who are expected to attend appointment:

Consultation Re: Interventions
 Staff Client Client Supports (specify): _____

Consultation Re: Transition Planning
 Staff Client Client Supports (specify): _____

Assessment to identify current needs
 Staff Client Client Supports (specify): _____

Diagnostic Assessment
 Staff Client Client Supports (specify): _____

DIAGNOSTIC INFORMATION

ASD diagnosis received? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Type of ASD Diagnosis <input type="checkbox"/> Autism Spectrum Disorder (ASD) <input type="checkbox"/> Asperger Syndrome <input type="checkbox"/> PDD-NOS <input type="checkbox"/> Other _____	Date of Diagnosis _____ / _____ / _____ <small style="text-align: center;">dd mm yyyy</small>
Where was diagnosis received?	Diagnosed by
Contact Address:	Phone: Email:
Other non-ASD Diagnoses?	
Please indicate if there are any behavioural concerns such as temper outbursts, violence, major anxiety issues, substance abuse issues and so on.	

If it is important for Deb to contact any of the professionals involved before providing the service, please have the client sign a release of information form with contact information for the professional involved. Attach the release of information form to this form.
 For younger adults who are seeking a diagnostic assessment, it is helpful to gather developmental history from parents. You may inquire as to whether they would agree to that and include parents on the release of information form.
 Please indicate if any past assessments have been completed and if copy is attached:

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|---|---------------|
| <input type="checkbox"/> Intellectual | copy attached |
| <input type="checkbox"/> psycho-educational | copy attached |
| <input type="checkbox"/> speech and language, | copy attached |
| <input type="checkbox"/> occupational therapy | copy attached |
| <input type="checkbox"/> vocational assessments | copy attached |