AUTISM SERVICES

609 25th Street East
Saskatoon SK S7K 0L7
Ph: (306) 665-7013 Ext 264 Fax: (306) 665-7014
Email: adultpsych@autismservices.ca
Website: www.autismservices.ca

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		☐ Male ☐ Female
Mailing Address No & Street or Box No. City Prov Postal Code		
Date of Birth DD/MM/YY	Home Ph:	Work Ph:
Email:		Cell Ph:

Living Situation:

- ☐ Lives Family of Origin
- ☐ Lives Alone
- ☐ Lives with Roommates
- ☐ Supported Living or Group Home
- ☐ Lives with Spouse and/or Children

Marital Status:

- ☐ Single
- ☐ Married or Common-in-law
- ☐ Separated or Divorced

Employment Status:

- ☐ Employed
- ☐ Supported Work Placement (Specify): _____
- ☐ Unemployed
- ☐ High School
- ☐ Vocational or Post Secondary Training (Specify): _____
- ☐ Disability
- ☐ 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:
Role & area of service: (eg. Psychologist, Mental Health)	Phone number: Email:

Mailing Address

No & Street or Box No. City Prov Postal Code

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? ☐ Yes ☐ No If yes, Type of ASD Diagnosis ☐ Autism Spectrum Disorder (ASD) ☐ Asperger Syndrome ☐ PDD-NOS ☐ Other _____	Date of Diagnosis _____/_____/_____ dd mm yyyy
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:

☐ Intellectual copy attached
☐ psycho-educational copy attached
☐ speech and language, copy attached
☐ occupational therapy copy attached
☐ vocational assessments copy attached