Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

AUTISM DIAGNOSTIC SERVICES REFERRAL FORM

Family is aware of this referral: Yes ❑ No ❑ (must be checked) Referral Date:_____(dd/mm/yy)

CLIENT INFORMATION:

Client Name: _____
Last Name First Name Middle Initial

Chosen Name:_____Preferred Pronoun:_____

Date of Birth:_____Gender:_____
Day / Month / Year

Client Address:_____

Apt/Unit #: _____City:_____Province:_____

Postal Code:_____Tel.:_____

Is an interpreter required? ☐ Yes ☐ No Language spoken:_____

If yes, would over-the-phone interpretation be possible for this client (i.e. is hearing/speaking an issue?) ☐ Yes ☐ No

Health Card Number:_____Version Code: ___Expiry Date: _____Province: _____

Interim Federal Health Program (IFHP) ☐Yes ☐No Health Card In Process ☐ Self-Pay ☐ 3rd Party ☐

Client lives with: ☐ Parent(s) / Legal Guardian(s) ☐ Separated / Split arrangement ☐ Under care of child protection agency/Foster family ☐ Extended family caregiver or Kinship caregiver ☐ Independent ☐ Group home ☐ Other: _____

Do you have any past experience with services offered at Holland Bloorview? **☐Yes ☐No**

Are there any decision-making or parenting time agreements (formerly referred to as custody and access) that the health care team should be aware of? ☐Yes ☐No

Primary Contact:

Name: _____Relationship to Child: _____

Address (if different from child):_____

Email:_____

Tel. (home):_____Tel. (cell):_____Tel. (work): _____

Secondary Contact:

Name: _____Relationship to Child: _____

Address (if different from child):_____

Email:_____

Tel. (home):_____Tel. (cell):_____Tel. (work): _____

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (e.g., Child Protection, Community)	Professional (e.g., OT, SLP, Psychologist)
1._____	_____
2._____	_____
3._____	_____

* R E F O U T P *

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MEDICAL INFORMATION:

Confirmed/Pending Diagnoses:

_____

Does this client require any special infectious disease precautions? ☐ Yes ☐ No
If yes, what for: _____

Medical History/Allergies:

_____

Taking Medication: ☐ Yes ☐ No
Please include PRN medications and provide details related to frequency, dose, effectiveness/response, side effects, etc.)
_____

Other information/Risks (e.g., frequent falls)

_____

_____

Reason for Referral/Concern/Goals:

_____

Query Autism
STEPS 1 AND 2 MUST BE COMPLETED

Step 1: Both boxes must be checked to be accepted

- ❑ Client has not been diagnosed with autism spectrum disorder
- ❑ A recent consult note or the client's current presentation is documented above, under "Reason for Referral/ Concern/Goals"

Step 2: Must pick 1 of the 3 options:

Option 1

❍ **I am referring for an autism assessment at Holland Bloorview**

Option 2

❍ **I want to partner with Holland Bloorview for an expedited assessment in the community** (Check one of the boxes below to select the community assessment you prefer for this client. See QR code below for details.)

❑ **30-min Collegial Consultation.** This is used when a physician has started the assessment and wants to discuss next steps.

Which clinician would you prefer to consult with? (Please check one box.)

- ○ Psychologist
- ○ Speech-Language Pathologist
- ○ First available

❑ **Virtual assessment.** FOR CHILDREN UNDER 6 YEARS ONLY. An SLP from Holland Bloorview leads the assessment online while the referring physician observes. They score the assessment together afterwards.

❑ **If you would like more information before you decide** between #1 and #2, please check this box and someone from Holland Bloorview will call you.

OR

❍ **Option 3**

❑ **Social work for families whose child was diagnosed with autism within the last 12 months**
(short-term consultation for resource navigation support)

○ **Please check this circle if the family cannot understand English proficiently in a group setting**

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REFERRING MD/NP/DDS Name: _____

OHIP Billing Number: _____

Referring provider is not the client's Primary Care Provider ☐

Hospital: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

*Please complete all sections of this form as incomplete forms will result in processing delays.
**NOTE: This information will be shared with Holland Bloorview staff as required.

Please fax your completed Referral Form to Appointment Services: (416) 422-7036

https://hollandbloorview.ca/services/programs-services/autism-services-community-pathways

Please use the link if any other outpatient services are required: https://hollandbloorview.ca/OutpatientReferralForm

REF OUTP