Physician Referral to KidsAbility ASD Assessment Team ONLY

Date: ______________________ **Phone**: ______________________

Referring Physician: Dr. ______________________ **Fax No.:** ______________________

(please print)

☐ **Parent/Legal Guardian Consent to refer received** **Address:** ______________________

Client Name: ______________________ **Date of Birth:** ______________________

Gender: ☐ Male ☐ Female **Health Card Number:** ______________ **Version Code:** __________

Parent/Legal Guardian Name: ______________________ **Relationship:** ______________________

Address: ______________________ **Phone:** ______________________

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Parent/Legal Guardian Name: ______________________ **Relationship:** ______________________

Address: ______________________ **Phone:** ______________________

Areas of Concern:

☐ receptive language

☐ expressive language

☐ social language

☐ social interaction

☐ sensory behaviours

☐ repetitive or ritual behaviour(s)

Reason for Referral:

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☐ Yes ☐ No Hearing has been tested

☐ Yes ☐ No Child wears hearing aids

☐ Yes ☐ No Vision has been tested

Please attach consultation notes/test results.

Referring Physician OHIP Billing #: ______________________

Referring Physician Signature: ______________________

PLEASE RETURN SIGNED REFERRAL FORM VIA FAX TO KIDSABILITY:

ATTENTION: CLIENT RECORDS

Fax: 519-886-7292

Questions? Call Jennifer at 519-886-8886 ext. 1373

If this child is provided with a diagnosis prior to being booked for an assessment with this team, please contact Jennifer at 519-886-8886 ext. 1373.