ISAND | INTEGRATED SERVICES FOR AUTISM AND NEURODEVELOPMENTAL DISORDERS

CLIENT AND FAMILY INFORMATION FORM: TRANSITION TO ADULTHOOD (15-25 YEARS)

Please complete all sections of this form to ensure prompt processing.
*** Denotes a required field**
NOTE: This information will be shared with ISAND staff as required

Please email, mail, fax or return this form in person:
Integrated Services for Autism and Neurodevelopmental Disorders
5734 Yonge Street, Suite 500 Toronto, ON Canada M2M 4E7

Telephone: 416.224.5959 Facsimile: 416.224.2772 Email: info@isand.ca

Charitable Registration No: 84141 7538 RR0001

Upon completion of this form:

Save the file by going to "file" then "save." Save it to your computer and then attach it into an email and send to info@isand.ca

COMPLETED BY: **TODAY'S DATE:**

CLIENT INFORMATION*

Last name: First name: Goes by:

Date of birth: Gender: Male Preferred Pronouns: he/him

Home address:

City: Province: Postal code:

Health card number: Version code: Expiry:

Language(s) spoken at home:

Any brothers/sisters? ◯ Yes ◯ No List by name (age):

PARENT/GUARDIAN INFORMATION*

PARENT/GUARDIAN 1 (PRIMARY CONTACT FOR APPOINTMENTS)

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. Last Name: First Name:

Occupation:

Address (if different from client's):

Primary telephone No.: ◯ Home ◯ Cell ◯ Work

Other telephone No.: ◯ Home ◯ Cell ◯ Work

Email address:

I prefer to be contacted by: ☐ Email ☐ Phone

PARENT/GUARDIAN INFORMATION (cont'd)

PARENT/GUARDIAN 2

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. Last Name: First Name:

Occupation:

Address (if different from client's):

Primary telephone No.: ◯ Home ◯ Cell ◯ Work

Other telephone No.: ◯ Home ◯ Cell ◯ Work

Email address:

I prefer to be contacted by: ☐ Email ☐ Phone

Emergency contact name*: Phone*:

RELATIONSHIP STATUS

◯ Married/Common-Law ◯ Separated ◯ Divorced ◯ Single ◯ Widow/Widower

The client currently lives with:

◯ Both parents ◯ Mother ◯ Father ◯ Grandparent(s) ◯ Foster Family ◯ Other

If under 16 years old; who has legal custody of the client?

◯ Both parents ◯ Mother ◯ Father ◯ Grandparent(s) ◯ Foster Family ◯ Children's Aid Society

◯ Other

EXTENDED HEALTH CARE COVERAGE AND FINANCIAL ASSISTANCE

Do you have any extended health care coverage through private and/or group insurance?

Parent/Guardian 1: ◯ Yes ◯ No ◯ Not sure

Parent/Guardian 2: ◯ Yes ◯ No ◯ Not sure

Do you receive any financial assistance? ◯ Yes (check all that apply) ◯ No

☐ Special Services at Home (SSAH)

☐ Assistive Devices Program (ADP)

☐ Disability Tax Credit

☐ Ontario Disability Support Program (ODSP)

☐ Funding via "Jordan's Principle" serving First Nations/Metis/Inuit

☐ Assistance for Children with Severe Disabilities (ACSD)

☐ Incontinence Supplies Grant Program (Easter Seals)

☐ Trillium Drug Program

☐ Other:

WHAT BRINGS YOU TO ISAND?*

How did you hear about ISAND?

◯ Doctor ◯ Friend ◯ Website ◯ Social Media ◯ Other:

What are some of your client's strengths and interests?

What are your main reasons for contacting ISAND? Please rank your top 3 in order of concern

1)

2)

3)

Is there a specific program or service you are interested in?

- ☐ Augmentative Communication (using pictures / tablet to talk) Behavioural Therapy
- ☐ Counseling – Individual and Family
- ☐ Developmental Medical Care
- ☐ Educational Consultation
- ☐ Occupational Therapy (sensory / motor needs / daily activities / leisure)
- ☐ Psychology Services – Developmental or Psycho-educational Assessment
- ☐ Psychology Services – Parent Consultation
- ☐ Social Peers Program (2 yrs - adolescent)
- ☐ Social Thinking Groups (10+ yrs)
- ☐ Feeling Social Group (10+ yrs)
- ☐ Speech and Language Therapy – Assessment
- ☐ Speech and Language Therapy – Intervention
- ☐ Yoga

Does the client have any allergies? ◯ Yes (please list below) ◯ No

HEALTH AND DEVELOPMENTAL INFORMATION*

PRENATAL HISTORY

Were there any worries about the pregnancy and possible effects on the client's development?
◯ Yes (please specify) ◯ No

Was pregnancy a stressful time? ◯ Yes (please specify) ◯ No

Were there any thyroid problems during pregnancy? ◯ Yes (please specify) ◯ No

Were there any fevers during pregnancy? ◯ Yes (please specify) ◯ No

Were any medications taken during the pregnancy (please specify)?

BIRTH HISTORY

Pre-term (weeks): Full term (38 weeks+): Birth weight:

Any concerns during delivery (please specify: ◯ vaginal delivery or ◯ c-section)?

Any interventions required (please specify)?

NEONATAL PERIOD

Any admission to special care baby unit? ◯ Yes (please specify) ◯ No

Severe jaundice requiring treatment? ◯ Yes (please specify) ◯ No

Early feeding: ◯ breast fed ◯ bottle fed ◯ both

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

CHILD DEVELOPMENT

When did the client achieve key milestones:

smiling	rolling over	sitting unaided	standing
babbling	speaking	toileting skills	

Normal growth – Is the client following weight and height percentiles? ◯ Yes ◯ No

Please specify

Gastrointestinal Issues (select all that apply, if selected, please specify)

- ☐ colic
- ☐ reflux
- ☐ constipation
- ☐ diarrhea
- ☐ other:

Has the client ever been diagnosed with any of the following? (please check all that apply, add date of diagnosis)

☐ Autism Spectrum Disorder	☐ Asperger Syndrome	☐ PDD-NOS
☐ Rett Syndrome	☐ Fragile X Syndrome	☐ Down Syndrome
☐ Tourette Syndrome	☐ Global Developmental Delay	☐ Cognitive Delay
☐ ADD/ADHD	☐ Anxiety or Mood Disorder	☐ Epilepsy or seizure disorder

☐ Other medical or genetic conditions (please specify):

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

Does the client have or experience any of the following? (select all that apply, if selected, please specify)

SELF-CARE / FINE & GROSS MOTOR / SENSORY

☐ Difficulty with personal hygiene: dressing / bathing or showering / cleaning teeth / toileting

☐ Difficulty following through with: chores homework sequencing tasks

☐ Difficulty using utensils to eat, cutting food

☐ Picky eating or limited diet

☐ Difficulty holding a pencil or printing

☐ Bothered by sensations: loud noise, bright light, clothing, certain textures

☐ Poor balance or coordination Difficulty engaging in leisure activities

For office use:

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

Does the client have or experience any of the following? (select all that apply, if selected, please specify)

EMOTIONAL REGULATION / BEHAVIOURAL CONCERNS

- ☐ Difficulty falling asleep or sleeping through the night
- ☐ Difficulty regulating his/her mood (worries, tantrums, withdraws, cries for no reason)
- ☐ Difficulty going from one activity to another / gets upset by changes in plans
- ☐ Bullies others
- ☐ Prone to be bullied or manipulated by others
- ☐ Difficulty participating in community outings (e.g., shopping, appointments, parties)
- ☐ Safety risk (wanders away, risky behaviour, threatens aggression or self-injury)

For office use:

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

RECEPTIVE LANGUAGE (COMPREHENSION) SKILLS

Are his/her language understanding skills similar to peers: ◯ **yes** ◯ **no / delayed** ◯ **advanced**

If No:

Does he/she respond when their name is called?	◯ yes	◯ no	◯ emerging
Can he/she follow 1 step commands in daily routines?	◯ yes	◯ no	◯ emerging
Can he/she follow two step commands?	◯ yes	◯ no	◯ emerging
Can he/she understand yes/no questions?	◯ yes	◯ no	◯ emerging
Can he/she understand who/what/where questions?	◯ yes	◯ no	◯ emerging
Can he/she understand when/why/how questions?	◯ yes	◯ no	◯ emerging

EXPRESSIVE LANGUAGE SKILLS (SPONTANEOUS)

Speech Level: ◯ sounds or words ◯ word phrases ◯ 3+ word phrases ◯ conversation

Intelligibility: How much of their natural speech can you understand? ◯ 25% ◯ 50% ◯ 75% ◯ 100%

How much can unfamiliar partners understand? ◯ 25% ◯ 50% ◯ 75% ◯ 100%

Other: Voice output device: ☐ Picture exchange system: ◯ photos? ◯ symbols? ◯ text?

Sign Language:

Gestures: ☐ waves hi/bye ☐ 'high 5' ☐ points ☐ leads by hand ☐ approaches people/items

Functions: ☐ greet ☐ request ☐ protest ☐ inform ☐ question ☐ socialize

HEALTH AND DEVELOPMENTAL INFORMATION* (cont'd)

SOCIAL COMMUNICATION

- ☐ Difficulty initiating conversation with peers
- ☐ Seems disinterested in peers OR tends to dominate interactions
- ☐ Difficulty making and/or maintaining friendships
- ☐ Has difficulty staying with topic shifts
- ☐ Misses social cues from others (sarcasm, gestures, facial expressions)
- ☐ Seems "obsessed" with certain topics or themes
- ☐ Talks too much or too little
- ☐ Has limited empathy or understanding of others' feelings

Comments:

MEDICATIONS OR SUPPLEMENTS*

Is the client currently taking any medication(s) or supplement(s)? ◯ Yes (please list below) ◯ No

Medication name	Dosage	Frequency	Date started	Effective(Y/N)?
				Yes
				Yes
				Yes
				Yes
				Yes
				Yes

Previous medications trialed: Outcome: Comments:

HEALTH CARE PROFESSIONALS*

Family Doctor Name: Phone #:

Paediatrician Name: Phone #:

Is this a developmental paediatrician? ◯ Yes ◯ No

ADDITIONAL SERVICES:

Social Worker / Psychologist Name: Phone #: ◯ Current ◯ Past

Speech-Language Pathologist Name: Phone #: ◯ Current ◯ Past

Occupational Therapist Name: Phone #: ◯ Current ◯ Past

Behavioural Therapist Name: Phone #: ◯ Current ◯ Past

Other service Name: Phone #: ◯ Current ◯ Past

Has the client had any of the following:

☐ Vision screening ☐ Hearing screening ☐ Genetic testing (findings)

☐ Neurologic tests (e.g., MRI, EEG; if selected please give result details)

Has the client had any overnight stays in hospital? ◯ Yes (please give details) ◯ No

EDUCATION*

Is the client enrolled in school? ◯ Yes (please complete below) ◯ No

Name of school: Grade:

Phone #: ☐ School board: OR ☐ Private school

What type of classroom is the client in?

◯ Fully integrated (Regular) ◯ Partially integrated ◯ Specialized

If Specialized specify: ◯ ASD class ◯ DD or Mild Intellectual Disability ◯ Gifted ◯ Immersion

Has the client's teacher expressed any concerns about his/her learning, development, or behaviour?

◯ Yes (please describe below) ◯ No

Has there been an IPRC (Identification, Placement, Review Committee) meeting? ◯ Yes ◯ No ◯ Not sure

Does the client have an Individualized Education Plan (IEP)? ◯ Yes ◯ No ◯ Not sure

Is the client on a modified or accommodated curriculum? ◯ Yes ◯ No ◯ Not sure

Does the client receive extra assistance at school?

◯ Yes (please describe below) ◯ No

☐ Educational assistant (if selected, please specify)

☐ Class withdrawal with Special Education Resource Teacher (if selected, please specify)

How many hours of the day?

What is the client's reading level? Reading comprehension level?

Has the client had any volunteer and/or paid employment experience?

◯ Yes (please describe below) ◯ No

Does the client participate in any clubs, teams or activity groups?

ADDITIONAL INFORMATION

Is there any other information you would like to share with us that would help us to understand the client or family's current situation?

I certify that all of the above information is true and accurate to the best of my knowledge and understanding.

SIGNATURE:

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