ISAND

INTEGRATED SERVICES FOR AUTISM AND NEURODEVELOPMENTAL DISORDERS

T 416-224-5959
F 416-224-2772
E info@isand.ca
www.isand.ca

5734 Yonge Street, Suite 500
Toronto, ON Canada M2M 4E7
Charitable Registration Number
84141 7538 RR0001

PHYSICIAN/CLINICIAN REFERRAL FORM

Referral Date (YYYY/MM/DD): _____

This client is referred for: ☐ **Developmental Pediatrician** *(doctor's referral required)* ☐ **Other Services**

Referral Source: ☐ **MD** ☐ **Health Care Professional** ☐ **Client and Family** ☐ **Other** _____

CLIENT INFORMATION:

Client Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Date of Birth (YYYY/MM/DD): _____ ○ **Male** ○ **Female**

Is an interpreter required? ○ Yes ○ No Languages spoken: _____

Client Address: _____

City: _____ **Province**: _____ **Postal Code**: _____

Health Card Number (include letters)**:** _____ **Health Card Expiry Date**: _____

Client Lives With: ☐ Mother ☐ Father ☐ Guardians ☐ Group Home ☐ Other: _____

Primary Contact – Parent/Legal Guardian:

Name(s): _____

Address *(if different from child's address)***:** _____

Email: _____ **Phone (cell):** _____

Secondary Contact – Parent/Legal Guardian *(if applicable)***:**

Name(s): _____

Address *(if different from child's address)***:** _____

Email: _____ **Phone (cell):** _____

ISAND | INTEGRATED SERVICES FOR AUTISM AND NEURODEVELOPMENTAL DISORDERS

MEDICAL INFORMATION:

Primary Diagnosis: _____

Other Diagnoses: _____

Pertinent Medical History/ Reason for Referral:

Risks (e.g. flight, falls, Aggression, etc.):

REFERRALS TO A DEVELOPMENTAL PAEDIATRICIAN AT ISAND

(check reason for referral):

☐ Query Autism ☐ Infant Developmental Services ☐ Psychopharmacology

☐ Other: _____

REFERRING MD Name: _____

OHIP Billing Number: _____

Hospital/Practice: _____

Phone: _____ Fax: _____

Signature: _____

REFERRALS TO OTHER SERVICES AT ISAND

(use check box for referral):

☐ Psychological Assessment & Intervention ☐ Behaviour Therapy ☐ Education Consultations

☐ Social Communication Intervention ☐ Speech-Language Therapy ☐ Social Work

☐ Diet And Nutrition Services ☐ Yoga & Movement Therapy ☐ Occupational Therapy

PLEASE EMAIL OR FAX THE COMPLETED REFERRAL TO:
E: INTAKE@ISAND.CA OR
F: 416-224-2772