



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
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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:

Preferred Pronouns:

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) Assistance for Children with Severe Disabilities (ACSD)

Assistive Devices Program (ADP) Incontinence Supplies Grant Program (Easter Seals)

Disability Tax Credit Trillium Drug Program

Ontario Disability Support Program (ODSP) Other:

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

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	2 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)?
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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: