INTEGRATED SERVICES FOR AUTISM AND NEURODEVELOPMENTAL DISORDERS

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Charitable Registration Number
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# 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):** ___________________________

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## 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**