Western Health

P. O. Box 2005, Corner Brook, NL, A2H 6J7
Telephone (709)784-5284 / Fax (709)637-5155

Autism Intervention Services

REFERRAL FORM

Child's Name: _____ Date of Birth: _____

MCP #: _____

School Grade: _____

Parent's Name: _____

Phone: _____

Address: _____

_____

Reason for Referral: _____

Please check all that apply:

□ Behavior Issues	□ Verbal
□ Sleep Difficulties	□ Non-verbal
□ Attention / Concentration	□ Sensory Issues
□ Impulsivity / Hyperactivity	□ Emotional Regulation Issues
□ Intellectual / Learning Difficulties	□ Safety Concerns
□ Feeding	□ Social Skills and/or Interpersonal Skills
□ Play	□ Anxiety / Fears

Referral Source: _____ Date:_____

Address: _____

_____

Is the family aware of this referral? ____ Yes ____ No

Is the documentation noting a diagnosis of Autism attached? _____ Yes ____ No

Is child in receipt of an ISSP? ____ Yes ____ No

Other referrals / Professional involvement:	**Psychology**	**____**	**Speech**	**____**
	Public Health	**____**	**Physio/OT**	**____**
	Other: _____			

Additional Comments: _____

_____

_____