McMaster Children's Hospital

Autism Spectrum Disorders (ASD) Diagnostic HUB Referral Form

Pathways Health Centre for Children
1240 Murphy Road, Sarnia, Ontario N7S 2Y6
Phone: (519) 542-3471 Fax: (519) 542-4115

PLEASE PRINT CLEARLY

Date of Request: (yyyy/mm/dd) _____

Date Last Seen: (yyyy/mm/dd) _____

Child's Last Name _____ First Name _____

Address _____

City _____ Postal Code _____

HIN _____ Version Code _____ Date of Birth: (yyyy/mm/dd) _____

Referral Source: Name _____ Address: _____

Phone: _____ Fax: _____ Email: _____

If Physician: Signature _____ OHIP Billing Number _____

Family Physician: _____ Phone: _____

Substitute Decision Maker / Legal Guardian:

Name	Relationship to Patient	Contact Number	Best time to call
_____	☐ Parent ☐ Other - _____	_____	☐ a.m. ☐ p.m.
	e-mail address _____		
_____	☐ Parent ☐ Other - _____	_____	☐ a.m. ☐ p.m.
	e-mail address _____		

Do you required an Interpreter? ☐ No ☐ Yes – what language? _____

Query Autism ☐

Description of child's current presentation and/or issues that lead to this question (Most recent/relevant consult note must be attached)

_____

_____

Specific Areas of Concern

A. Social, Communication and Interaction Skills (Please provide specific examples of all 3 below)

Social-emotional reciprocity- e.g., limited initiation of social interaction, reduced sharing of emotions/affects, peer social imitations etc. Provide examples:

_____

_____

Non-verbal communication e.g., poor use/understanding of gestures, impaired eye contact, poor use /understanding of affect etc. Provide examples

_____

_____

Development of relationships with peers of the same developmental level- e.g., lack of interest in peers, limited sharing of imaginary play, difficulty making friends, etc. Provide examples:

_____

_____

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PLEASE PRINT CLEARLY

B. Restricted, Repetitive Behaviours, Interests/Activities (Please provide specific examples for a minimum of 2 below)

Stereotyped/repetitive speech, motor movements, or use of objects- e.g., Echolalia, repetitive vocalizations, finger/arm movements, abnormal posture etc. Provide examples

_____

_____

Routines/rituals/resistance to change- e.g., strict adherence to specific routines, rigid thinking, verbal or non-verbal rituals/compulsions etc. Provide examples

_____

_____

Preoccupation/intense interests- e.g., intense interest in certain objects/topics, intense interest in unusual objects/topics, strong attachment to unusual objects. Provide examples

_____

_____

Sensory responses- e.g., hyper or hypo reactivity to sensory input, unusual sensory input. Provide examples.

_____

_____

Additional concerns noted from parents/caregivers- check all that apply

- ☐ Loss of skills
- ☐ Self-injurious behavior
- ☐ Hyperactivity/Impulsivity
- ☐ Anxiety
- ☐ Safety concerns
- ☐ Tantrums/aggression/disruptive behavior

Other professionals/services currently involved: ☐ **CAS** ☐ **CCAS** ☐ **Other:** _____

_____

Other relevant diagnoses, conditions: _____

_____

_____ ☐ Current Allergy List faxed with Referral

Relevant medical / psychiatric / safety concerns regarding the family: _____

_____

_____

Please fax legibly completed form and any accompanying documentation to (519) 542-4115. Incomplete forms will be returned to the referral source. Families will be contacted directly to book their appointment.

Hamilton Health Sciences

For Internal Use Only – Pt. ID Number _____

CONSENT TO DISCLOSE PERSONAL AND / OR PERSONAL HEALTH INFORMATION – BIDIRECTIONAL

Date: (yyyy/mm/dd) _____ **RE:** Patient Name: _____

Substitute Decision Maker Identification

Name: _____

Address and Phone Number: _____

_____

Relationship to Patient: _____

1. I am at least 16 years old or I am under 16 years and the parent of the incapable patient
2. I believe that the incapable patient, when capable, would not have objected to me deciding about the disclosure of health information.
3. I believe that no one ranking higher than me, or the same rank as me, claims authority and is available and willing to decide about the disclosure of personal health information.

Choose one of the following:

a) Court Appointed Guardian
b) Power of Attorney
c) Representative appointed by the Consent Capacity Board
d) Spouse or Partner
e) Parent or Child
f) Parent with a right of access
g) Brother or sister
h) Any other relative related by blood, marriage or adoption

Date (yyyy/mm/dd) _____ Signature of Substitute Decision Maker _____

STATEMENT BY INTERPRETER: I have done my best to accurately translate this form for the person requesting the release of information.

_____ _____ (____) _____

Printed Name | Signature | Phone Number

Autism Spectrum Disorder (ASD) Diagnostic Hub - West Region affiliated partners

- **Child and Parent Resource Institute (CPRI)**
  Ministry of Children, Community and Social Services
  600 Sanatorium Rd., London, ON, N6H 3W7
- **Children First**
  2565 Ouellette Ave, Suite 105, Windsor, Ontario N8X 1L9
- **Children's Treatment Centre of Chatham-Kent**
  355 Lark Street, Chatham, ON, N7L 5B2
- **Contact Niagara**
  (Intake for Bethesda, services for children over 6 years)
  3 Hanover Dr. #8, St. Catharines, ON, L2W 1A3
- **Pathways Health Centre for Children**
  1240 Murphy Road, Sarnia, ON, N7S 2Y6
- **Chris Brown -**
  Saint Thomas Psychoeducational Assessments
  # 103-460 Wellington St. St. Thomas ON N5R 6H9
- **Lansdowne Children's Centre**
  39 Mt Pleasant St., Brantford, ON, N3T 1S7
- **LaRose Psychology Corp**
  1615 N Routledge Park, Unit 35, London, ON, N6H 5N5
- **McMaster Children's Hospital,**
  Ron Joyce Children's Health Centre site
  325 Wellington St. North, Hamilton, ON, L8L 0A4
  Phone: 905 521-2100 X-78222, Fax: 905 577-8029
- **Niagara Children's Centre, (children under 6 years)**
  567 Glenridge Ave., St. Catharines, ON, L2T 4C2
- **Thames Valley Children's Centre**
  79 Base Line Rd. East, London, ON, N6C 5Y6
- **Brightshores Health System**
  1800 8th St. East, Owen Sound, ON, N4K 6M9

(Patient / SDM is to keep a copy of this consent upon completion)

Hamilton Health Sciences

For Internal Use Only – Pt. ID Number _____

CONSENT TO DISCLOSE PERSONAL AND / OR PERSONAL HEALTH INFORMATION – BIDIRECTIONAL

I _____, hereby authorize Hamilton Health Sciences
(Print Name)

Corporation to **Disclose personal information** *(which may include health information)* **to:**

Autism Spectrum Disorder (ASD) Diagnostic Hub - West Region, affiliated partners

- **LaRose Psychology Corp**
- **McMaster Children's Hospital**
- **Children First**
- **Brightshores Health System**
- **Lansdowne Children's Centre**
- **Contact Niagara**
- **Thames Valley Children's Centre**
- **Child and Parent Resource Institute (CPRI)**
- **Pathways Health Centre for Children**
- **Children's Treatment Centre of Chatham-Kent**
- **Niagara Children's Centre**
- **Chris Brown**

(Detailed partner information on page 2)

From the records of: _____ Date of Birth: _____
(Print name of patient) *(year / month / day)*

Health Card Number _____ Phone Number: _____

The type of personal information to be disclosed is:

_____.

I understand that this personal (health) information is to be used only by the recipient for the purposes of: _____.

I also authorize Hamilton Health Sciences Corporation to **Obtain personal information** *(which may include health information)* **from** the same individual / organization as indicated above.

The type of personal information to be obtained is:

_____.

I understand that this personal (health) information is to be used only by Hamilton Health Sciences for the purposes of: _____

_____

I hereby waive any and all claims against Hamilton Health Sciences Corporation in connection with the disclosure of this personal and/or personal health information.

I have read and understood the information above, and the purpose of information sharing. I understand that I can withdraw my consent at any time.

(year / month / day)	*Printed Name of Patient or Substitute Decision Maker*	*Signature of Patient or Substitute Decision Maker*

Witness Printed Name _____ _____

Witness Signature _____ *If substitute decision maker, specify relationship to patient* ***and complete information on reverse***

This form is valid for the purposes described above, for the duration that the patient is being cared for at Hamilton Health Sciences (program / service) _____, **but not to exceed 12 months from the date of signing.**