

## North East Ontario Autism Program

PLEASE PRINT, COMPLETE and FAX with **confirmation of diagnosis of ASD** to either:

- ❖ One Kids Place Children's Treatment Centre at (705) 474-0127
- ❖ Hands TheFamilyHelpNetwork.ca at (705) 495-1373

Or MAIL to either:

- ❖ One Kids Place Children's Treatment Centre  
400 McKeown Avenue North Bay, Ontario, P1B 0B2      Tel: (705) 476-5437 or 1-866-626-9100
- ❖ Hands TheFamilyHelpNetwork.ca  
222 Main Street East, North Bay, Ontario P1B 1B1      Tel: (705) 476-2293 or 1-800-668-8555

**PLEASE DO NOT E-MAIL**

Information provided by: \_\_\_\_\_ (i.e., family member/doctor/teacher)

Telephone: \_\_\_\_\_

Who recommended you make this referral? \_\_\_\_\_ (i.e., agency/therapist/family/doctor/teacher.)

Name of Child/Youth (Last, First, Initial):		Date of Birth (Day, Month, Year):		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Address:					
Postal Code:			Telephone:		
Health Card Number and Version :			Family Doctor:		Phone:
Pediatrician:		Phone:	School / Daycare:		Grade:
E-mail Address:			Language(s) Spoken by the Child: Language(s) Spoken by Parent/Guardian:		

### Family Information

Mother's Name:		Address ( <input type="checkbox"/> same as above):		Telephone (Home): (Work):	
Father's Name:		Address ( <input type="checkbox"/> same as above):		Telephone (Home): (Work):	
Custody Status: <input type="checkbox"/> Both		<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other / Special arrangements	
Legal Guardian:		Relationship to Child:	Phone:	Address:	

Diagnosis(es):	Diagnosis(es) Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No
By Whom:	Date: Reports Attached: <input type="checkbox"/> Yes <input type="checkbox"/> To Follow
Where did you learn about this program: _____ (i.e. other agency/information session)	
<b>Please identify the areas of need (check all boxes that apply)</b>	
<input type="checkbox"/> Social/Interpersonal <input type="checkbox"/> Communication <input type="checkbox"/> Cognitive Functions <input type="checkbox"/> School Readiness <input type="checkbox"/> Vocational	<input type="checkbox"/> Motor <input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Play <input type="checkbox"/> Self-Regulation <input type="checkbox"/> Challenging Behaviour
Explain: _____ _____	

The child/youth/family agrees with this referral to the North East Ontario Autism Program (OAP) lead agencies (Hands The FamilyHelpNetwork.ca and One Kids Place) and consents to the sharing of information with the relevant partner agencies in the program for processing this referral and admission to the program (North East Ontario Children and Family Services and Child and Youth Milopemahtesewin Services).  Yes  No

The child/youth/family agrees with the referral to the North East Ontario Autism Program (OAP) including the collection and sharing of information with the North East Ontario Autism Program (OAP) Central Waitlist (co-managed by Hands and One Kids Place).  Yes  No

The youth/family agrees to the use of their e-mail address by the North East Ontario Autism Program (OAP) for the purpose of communicating upcoming events and educational opportunities.  Yes  No

Who has provided consent?  Child/Youth  Parent/Guardian

Verbal Consent Obtained (for telephone referrals only):  Yes Signature: \_\_\_\_\_

Signature for the written consent for the sharing of information \_\_\_\_\_ Date \_\_\_\_\_

**FOR USE BY INTAKE ADMINISTRATION ONLY**

Completed by: Receiving agency: <input type="checkbox"/> OKP <input type="checkbox"/> Hands	Referral received by: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> In Person <input type="checkbox"/> Phone
<input type="checkbox"/> Meets residency and age requirements	<input type="checkbox"/> Consent to share information within NEOAP agencies obtained
<input type="checkbox"/> Diagnosis received <input type="checkbox"/> Letter <input type="checkbox"/> Report Date: _____ Time: _____	<input type="checkbox"/> Diagnosis confirmed Signature: _____ Date: _____

The lead agencies of the North East Ontario Autism Program may contact families in the future for research and evaluation purposes.

“The personal information being collected on this form is collected under the authority of the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act & Personal Information Protection & Electronic Documents Act. This information shall be used to ensure necessary health care measures are attained. Questions covering the collection of this information may be directed to One Kids Place Children’s Treatment Centre or Hands TheFamilyHelpNetwork.ca”