Saskatchewan Health Authority

Autism Spectrum Disorder (ASD) Department
1000B Albert Street
Moose Jaw, SK S6H 2Y1
P: 306-691-2308| F: 306-691-2330

ASD Program Referral

The Autism Spectrum Disorder Program provides a specialized service to children presenting with symptoms associated with an Autism Spectrum Disorder. Diagnosis is not necessary for services.

Please send referrals by email, fax or mail to:

Email	Fax	Mail
SHAASDMooseJaw@saskhealthauthority.ca	**306-691-2333**	**1000B Albert St Moose Jaw, SK S6H 2Y1**

REFERRAL AND CONSENT FOR REFERRAL				
Referred by:**			**Date:**	
Position:				
Phone #:		**Email:**		

Referral discussed with parent or guardian? ☐ **Yes** ☐ **No**

***Original referent is the primary contact person*

CLIENT INFORMATION:			
Client's Legal Name:		**DOB:**	
SK Health #:		☐ **Male** ☐ **Female**	
Mailing Address:		**Postal Code:**	
Street Address: (rural)			

PARENT OR GUARDIAN INFORMATION			
1. Name of Parent:			
Home/Cell #:		**Work #:**	
Email:			
2. Name of Parent:			
Home/Cell #:		**Work #:**	
Email:			

Client Siblings:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Custody / Parental Relationship:

☐ Lives with both parents ☐ Shared Custody ☐ Sole custody, I certify that the above listed child is under my sole custody, and I can provide a legal custody agreement to verify.

Parent signature:	If child is in foster care – Social Worker Name:	
	Phone #:	

REASON FOR REFERRAL

☐ Consultation ☐ Screening/Assessment ☐ Other

Briefly describe the nature of your request:

Please check applicable boxes below:

☐ Reduced social interactions	☐ Difficulties making/keeping friends
☐ Limited verbal words	☐ Decreased play skills/interaction with toys
☐ Decrease in back-and-forth communication	☐ Repetitive movements/behaviours
☐ Reduced interest in sharing	☐ Insistence on sameness/ritual/patterns
☐ Reduced emotions/facial expressions	☐ Difficulty with transitions
☐ Limited eye contact	☐ Difficulties understanding non-verbal communication
☐ Decreased understanding of emotions	☐ Fixated interests
☐ Limited use of gestures	☐ Over/Under reaction to sensory input
☐ Lacking joint attention	☐ Other: (please specify)

SUMMARY OF RELEVANT BACKGROUND INFORMATION

(Please attach relevant professional reports)

Professionals Currently or Previously Providing Services/Funding (Name and Phone # if known)

☐ Family Physician:	☐ Social Services:
☐ Early Childhood Psychologist:	☐ Teacher:
☐ Ed. Psychologist:	☐ Student Support Teacher:
☐ Clinical Psychologist:	☐ Special Ed. Consultant:
☐ Pediatrician:	☐ Community Living Division:
☐ Psychiatrist:	☐ Cognitive Disability Strategy:
☐ Speech Language Pathologist:	☐ Sask. Assoc. Comm. Living:

☐ Physical Therapist:	☐ Individualized Funding:
☐ Occupational Therapist:	☐ Other: (please specify)
☐ Mental Health/Addictions:	

DIAGNOSTIC INFORMATION

ASD Diagnosis made? ☐ Yes ☐ No

Diagnosed by:	
Date:	

If child is under 12 have you completed application for Individualized Funding? ☐ Yes ☐ No

Other diagnoses & name of professional who gave diagnoses:

EDUCATION (if applicable)

Current School:			
School Division:		Grade:	
Contact Person:			

DAYCARE (if applicable)

Name of Daycare Provider:	
Contact Person:	

One-to-One Support worker: ☐ Yes ☐ No