KidsAbility™

Physician Referral to KidsAbility
ASD Assessment Team ONLY

Date: _____ **Phone**: _____

Referring Physician: Dr. _____ **Fax No.:** _____

(please print)

☐ **Parent/Legal Guardian Consent to refer received** **Address:** _____

Client Name: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female **Health Card Number:** _____ **Version Code:** _____

Parent/Legal Guardian Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Parent/Legal Guardian Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Areas of Concern:

- ☐ receptive language
- ☐ expressive language
- ☐ social language
- ☐ social interaction
- ☐ sensory behaviours
- ☐ repetitive or ritual behaviour(s)

Reason for Referral:

_____

_____

_____

_____

_____

_____

Please attach consultation notes/test results.

Referring Physician OHIP Billing #: _____

Referring Physician Signature: _____

PLEASE RETURN SIGNED REFERRAL FORM VIA FAX TO KIDSABILITY:
ATTENTION: CLIENT RECORDS
Fax: 519-886-7292

Questions? Call Jennifer at 519-886-8886 ext. 1373
If this child is provided with a diagnosis prior to being booked for an assessment with this team, please contact Jennifer at 519-886-8886 ext. 1373.