Physician Referral to KidsAbility
Autism Spectrum Disorder (ASD) Assessment Team

Date of Referral: ______________________________ **Date Last Seen:** ______________________________

Referring Physician: Dr. ________________________ **Address:** ____________________________________

Email: ______________________________________ **Phone:** _______________ **Fax:** ____________________

OHIP Billing Number: ______________________________ **Physician Signature:** ________________________

Child's First & Last Name: __________________________________ **Gender:** _______ **Pronouns:** __________

Address: ____ **City:** _______________ **Postal Code:** _________

Date of Birth*: __________________ **Health Card Number:** ______________________ **Version Code:** ________

***Please Note: Due to wait time for assessment, we are unable to accept referrals for clients over the age of 16 yrs**.

Parent/Legal Guardian Name: ______________________________ **Relationship:** __________________________

Email*: ____ **Phone:** ____________________

Address (if different from child): ____

Parent/Legal Guardian Name: ______________________________ **Relationship:** __________________________

Email*: ____ **Phone:** ____________________

Address (if different from child): ____

Does the family require an interpreter? ☐ No ☐ Yes – what language? ________________________________

Areas of Concern:

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

Reason for Referral:

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☐ Has this child been referred anywhere else for an ASD Assessment? If yes, where? ________________________

☐ Parent/legal guardian gives consent for this referral AND understand this assessment is to determine if their child meets the DSM-5 criteria for a diagnosis of Autism Spectrum Disorder (ASD) only.

☐ *Parent/legal guardian give consent for use of email to receive information about referral, and/or to schedule appointments.

Please attach consultation notes, recent test results, or any other relevant documentation.

Please fax completed referral form to **KidsAbility, Attention Client Records** at 519-886-7292
If you have questions, please contact 519-886-8886 ext. 1373