ONE KIDS PLACE
LA PLACE DES ENFANTS
CHILDREN'S TREATMENT CENTRE
CENTRE DE TRAITEMENT POUR ENFANTS

Hands TheFamilyHelpNetwork.ca
Mains LeReseaudaideauxfamilles.ca

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 (Last, First, Initial):		Date of Birth (Day, Month, Year):	Sex: ☐ M ☐ F
Address:			
Postal Code:		Telephone (Home):	
Health 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 (☐ same as above):		Telephone (Home): (Work):
Father's Name:	Address (☐ same as above):		Telephone (Home): (Work):
Custody Status: ☐ Both	☐ Mother	☐ Father	☐ Other/ Special arrangements
Legal Guardian:	Relationship to Child:	Phone:	Address:

Diagnosis(es): Diagnosis(es) Confirmed ☐Yes ☐ No

By Whom: Date: Reports Attached: ☐Yes ☐ To Follow

Where did you learn about this program:_____(i.e. other agency/information session)

Please identify the areas of need (check all boxes that apply

- ❒ **Social/Interpersonal**
- ❒ **Communication**
- ❒ **Cognitive Functions**
- ❒ **School Readiness**
- ❒ **Vocational**
- ❒ **Motor**
- ❒ **Activities of Daily Living**
- ❒ **Play**
- ❒ **Self-Regulation**
- ❒ **Challenging Behaviour**

Explain:_____

_____

Child/youth/family agrees with this referral to the North East Ontario Autism Program (OAP) lead agencies (Hand The FamilyHelpNetwork 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

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

Youth/family agrees to the use of their e-mail address by the North East Ontario Autism Program (OAP) for the purposes 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: OKP ☐ HANDS ☐	Referral received by: ☐ Fax ☐ Mail ☐ In Person ☐ Phone
☐meets residency and age requirements	☐Consent to share information within NEOAP agencies obtained
☐Diagnosis received ☐letter ☐ report Date: _____ Time:_____	☐ Diagnosis confirmed Signature: _____ Date: _____

The lead agencies of the North East Ontario Autism Program may contact families in the future for research and evualtion 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 or HANDS TheFamilyHelpNetwork.ca"

Revised June /17