



NL Health Services

Corner Brook Community Health Centre
1 Brookfield Avenue, Corner Brook, NL, A2H 6J7
Telephone (709)784-5284 / Fax (709)637-5155

Autism Services REFERRAL FORM

Child's Name: _____ **Date of Birth:** _____

MCP #: _____

School Grade: _____

Parent's Name: _____

Phone: _____

Address: _____

Reason for Referral: _____

Please check all that apply:

<input type="checkbox"/> Behavior Issues	<input type="checkbox"/> Verbal
<input type="checkbox"/> Sleep Difficulties	<input type="checkbox"/> Non-verbal
<input type="checkbox"/> Attention / Concentration	<input type="checkbox"/> Sensory Issues
<input type="checkbox"/> Impulsivity / Hyperactivity	<input type="checkbox"/> Emotional Regulation Issues
<input type="checkbox"/> Intellectual / Learning Difficulties	<input type="checkbox"/> Safety Concerns
<input type="checkbox"/> Feeding	<input type="checkbox"/> Social Skills and/or Interpersonal Skills
<input type="checkbox"/> Play	<input type="checkbox"/> Anxiety / Fears

Referral Source: _____ **Date:** _____

Address: _____

Is the family aware of this referral? _____ **Yes** _____ **No**

Is the documentation noting a diagnosis of Autism attached? _____ Yes _____ No

Is child in receipt of an ISSP? _____ Yes _____ No

Other referrals / Professional involvement: Psychology _____ Speech _____
Public Health _____ Physio/OT _____
Other: _____

Additional Comments: _____

