Provincial Autism Services and Supports (PASS)

AUTISM ASSESSMENT TEAM

P.O. Box 2005, WMRH, Corner Brook, NL, A2H 6J7
Telephone: (709) 784-6655 Fax: (709) 637-5155
E-mail: autismintake@westernhealth.nl.ca

REFERRAL FORM

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

TELEPHONE #: _____ E-MAIL: _____

MCP #: _____ - _____ - _____ - _____ FAMILY PHYSICIAN: _____

Reason for Referral *(Please indicate concerns in each of these area as it relates to Autism)*

Social: _____

Communication: _____

Behaviour: _____

History: _____

Please indicate if the individual has been seen or referred to any of the following services:

Seen	Referred		Seen	Referred	
☐	☐	Psychology	☐	☐	Occupational Therapy
☐	☐	Audiology	☐	☐	Physiotherapy
☐	☐	Speech-Language Pathology	☐	☐	Direct Home Services Program
☐	☐	Paediatrician/Psychiatrist (please specify): _____			

Signature of Referral Source: _____

Address of Referral Source: _____

Telephone: _____ Date: _____

Check here to confirm client/caregiver(s) has been informed of this referral ☐

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