Hôpital de Montréal pour enfants
Centre universitaire de santé McGill
Montreal Children's Hospital
McGill University Health Centre

BDB ASD Clinic ages 13-17
Centralized Intake Referral Form

1001, boul. Décarie, Room A04-3140 Montreal, Québec, H4A 3J1
Telephone: (514) 412- 4496 Fax: (514) 412- 4136
Email: bdbci@muhc.mcgill.ca

Referral date (yyyy/mm/dd):

Patient Information (please print):

Date of birth		**MCH File no.**
Last name, First name		
Current address	**City, Province**	**Postal Code**
Home telephone number		**Other telephone number**
Email		**Language** ☐ French ☐ English Other: _____ ☐ Interpreter needed

Please specify the following: *NB if child does not meet this criteria, please redirect the request to the patient's local CIUSSS / CISSS*

☐ Child resides within one of the following McGill RUISSS sectors: *Nunavik, Outaouais, Cree Territory, West-Central Montreal and the West Island of Montreal, Nord du Québec, Montérégie-Ouest, Abitibi-Temiscamingue*
AND / OR
☐ Actively followed by related tertiary service(s) at MCH (*e.g. Neurology, Psychiatry, Oncology, etc.*). *Specify*: _____

AND

☐ Presents with neurodevelopmental delays/deficits associated with a complex medical condition and/ or complex psychosocial situation (e.g. DYP involvement) requiring tertiary evaluation. *Specify:*_____

Please describe your concerns and age of patient at referral:

Please attach any additional information on a separate page.

Please select appropriate evaluation, specify reasoning & provide required information:

☐ **ASD diagnostic assessment (13-17yo)** ☐ Parents or patients 14yrs or older have been informed of the suspicion of autism

NB. Patients referred by an external source must first be referred to their local CIUSSS to be triaged to the appropriate diagnostic clinic or service within the CIUSSS or appropriate hospital centre. (Referrals will be sent to/ accepted by BDB only if they meet criteria for a *tertiary* assessment).

☐ Significant social difficulties: _____
☐ Communication limitations: _____
☐ Atypical or repetitive behavior:_____
☐ Medical condition. *Specify*:_____
☐ Other: _____

Please indicate current medications

Medication	Dosage	Duration (wks or mon/ yr)

Please indicate if child is on the wait list or currently followed by these community services: *Please specify name & coordinates*

☐ **CRDP** (Centre de réadaptation en déficience physique) *Specify :* _____
☐ **CRDI-TSA** (Centre de réadaptation en déficience intellectuelle & Trouble du spectre de l'autisme) *Specify* : _____
☐ **CLSC / CIUSSS** (e.g. mental health or psychosocial services) *Specify:*_____
☐ **Youth Protection Services** (e.g. DYP / Batshaw) *Please provide coordinates of delegate(s):* _____
☐ **Other:** _____

Previous assessments: *Please include reports*

☐ Audiology ☐ Occupational Therapy ☐ Speech Language Pathology ☐ Psycho-education ☐ Psychology ☐ Psychiatry
☐ Other: _____

Referral Source:

Name of Referring Physician or Nurse Practitioner (please print): License number:

Address:

Telephone number: Fax number:

Name of Treating Physician (if different): **Signature**:

☐ ***PARENT(S) AND PATIENT OR PATIENT 14 YEARS AND OLDER ARE INFORMED OF THIS REFERRAL AND AGREE***

☐ **Patient over age 14 yrs authorizes** our clinic to contact parent/guardian about referral & appointment **OR** ☐ **does NOT authorize** contact with parent/guardian
Please provide direct contact info. for patient: PT cell (_____) _____-_____ PT Email:_____