School-Age Autism Diagnostics
Phone: 1-833-489-2100
Fax: (902) 428-9816
Email: schoolageautism.referral@iwk.nshealth.ca

REFERRAL FORM

Please use this form to request a diagnostic assessment for children/youth living anywhere in Nova Scotia in grade primary and above.

Please check one: ☐ **New Assessment**
☐ **Diagnostic re-assessment (please describe):** _____

Name of Child/Youth:	(First name) (Surname)	**DOB:** (dd/mmm/yyyy)	
Health Card No.:		**IWK Unit#:** (if applicable)	
Primary Address: (include postal code)		**Secondary Address:** (If applicable)	
Family Physician or Nurse Practitioner:		**Pediatrician:**	

Caregiver:		**Relationship to child:**	
Email:		**Phone:**	
Caregiver:		**Relationship to child:**	
Email:		**Phone:**	
Caregivers provided consent for email communication: ☐ **Forms to be sent** ☐ **Appointment reminders**			
Does the family require assistance in completing forms? *(i.e., reading/comprehension challenges, language barriers)*	☐ **Yes** ☐ **No** ☐ **Unclear**		
Need for interpreter:	**Caregivers:** ☐ **Yes** ☐ **No** ☐ **Unclear**	**Child:** ☐ **Yes** ☐ **No** ☐ **Unclear**	
Any other special considerations for this child/family:			

Name of referral source:		**Profession:**	
Contact information (phone/email):			

Signature of referral source: _____ **Date:** _____

Signature by the referral source indicates parent/guardian has consented to this referral being sent to the School-Age Autism Team. All referrals are placed on the IWK Health Record.

Other Documentation and Services:

☐ Check and describe if supporting documentation is attached (e.g., reports from other professionals):
☐ Check and describe if child is involved in or has been referred to other services (e.g., community mental health, neuropsychology):

Diagnostic Symptoms:

**Note: please complete as many of the boxes below; this will help us determine if the referral is appropriate for the clinic. If not enough information is provided, we may contact you for more details.*

For the below symptoms, please provide examples of behaviour that you have observed.
If you have not observed any behaviour in the category, but someone has reported it, please note who has reported it to you (e.g., caregiver, teacher, other professional, etc.)

SOCIAL-COMMUNICATION AND INTERACTION	
Please list any differences in **social-emotional reciprocity** *(e.g., approaching and responding to others; sharing interests or enjoyment; having flexible back and forth conversations)*	
	Check if you have observed these behaviours: ☐ If not, indicate who reported these behaviours to you: _____
Please list any differences in the **use and/or understanding of nonverbal communication** *(e.g., using gestures, eye contact, and facial expressions to communicate with others; reading other peoples' nonverbal cues)*	
	Check if you have observed these behaviours: ☐ If not, indicate who reported these behaviours to you: _____
Please list any difficulties in **forming and maintaining relationships** with others *(e.g., developing reciprocal friendships with others of the same age; play skills, including imaginative play)*	
	Check if you have observed these behaviours: ☐ If not, indicate who reported these behaviours to you: _____

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RESTRICED, REPETITIVE PATTERNS OF BEHAVIOUR, INTERESTS, OR ACTIVITIES	
Please list any **stereotyped or repetitive motor movements, use of objects, or speech** *(e.g., hand flapping, lining up toys, repetitive actions with objects, repeating others' language)*	
	Check if you have observed these behaviours: ☐ If not, indicate who reported these behaviours to you: _____
Please list any examples of **insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior** *(e.g., extreme distress at small changes, significant difficulties with transitions, inflexible thinking patterns)*	
	Check if you have observed these behaviours: ☐ If not, indicate who reported these behaviours to you: _____
Please list any **highly restricted, fixated interests that are unusual in intensity or focus** *(e.g., strong attachment to or preoccupation with unusual objects, extremely strong or very unusual interests)*	
	Check if you have observed these behaviours: ☐ If not, indicate who reported these behaviours to you: _____
Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment *(e.g., very strong response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement)*	
	Check if you have observed these behaviours: ☐ If not, indicate who reported these behaviours to you: _____

FUNCTIONAL IMPAIRMENT	
Do the challenges listed above result in clear functional impairment? *(Please note that this should be beyond a dislike/preference for something. There should be a significant impact on the life of the child and/or the lives of those around them.)*	☐ **Yes** ☐ **No**
If yes, please describe how (if not already described above):	