Preschool Autism Diagnostics
Provincial Preschool Autism Service
Phone: 1-833-200-7817
Fax: 902 428-9931
referrals-preschoolautism@iwk.nshealth.ca

PRESCHOOL AUTISM DIAGNOSTICS REFERRAL FORM

Please use this form to request a diagnostic assessment for children living anywhere in Nova Scotia who have not yet started grade primary.

REASON FOR REFERRAL
☐ **New Diagnostic Assessment** (autism spectrum)
☐ **Diagnostic Reassessment** (please describe)

Name of Child:	(given name/s) (surname/s)		**Date of Birth:**	(dd/mm/yyyy)
Health Card No.:		**IWK Unit#:** (if applicable)		
Primary Address: (include postal code)		**Secondary Address:** (If applicable)		
Family Physician/ Nurse Practitioner:		**Pediatrician:**		

Caregiver:		**Relationship to child:**	
Email:		**Phone:**	
Caregiver:		**Relationship to child:**	
Email:		**Phone:**	
☐ **Caregiver provides consent for email communication**			
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 special considerations for this child/family: *(e.g., new Canadians, languages spoken at home, existing diagnoses).*			

Please continue to Page 2 to complete the full referral form.

Signs of Autism:

Please complete both boxes below.

A) SOCIAL-COMMUNICATION AND INTERACTION
Please describe any differences in: • **social-emotional reciprocity** *(e.g., approaching and responding to others, sharing interests and enjoyment, having back and forth conversations)* • **nonverbal communication** *(e.g., pointing, eye contact, responding to name)* • **play and social interaction** *(e.g., seeking out children of the same age, pretend play)*
Have you observed any of these social social-communication differences? Yes ☐ No ☐ If not, indicate who reported these behaviours to you:
B) RESTRICED, REPETITIVE PATTERNS OF BEHAVIOUR, INTERESTS, OR ACTIVITIES
Please describe any: • **stereotyped or repetitive motor movements, use of objects, or speech** *(e.g., hand flapping, lining up toys, repeating others' speech)* • **significant difficulty coping flexibly** *(e.g., distress at small changes, clear upset when routines change)* • **intense, focused interests** *(e.g., extremely strong interests, unusual interests)* • **clear sensory differences** *(e.g., very strong response to certain sounds or textures, frequent smelling or touching of objects, looking at objects very closely)*
Have you observed any of these behaviours? Yes ☐ No ☐ If not, indicate who reported these behaviours to you:
☐ **Check and describe if supporting documentation is attached:**
Other comments:

Name of referral source:		**Profession:**	
Phone:		**Email:**	

Signature of referral source: _____ Date:

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