Alberta Health Services

Affix patient label within this box

Adult Autism Diagnostic and Consultation Service Referral

To Be Completed By Physician/Nurse Practitioner

Referral for: ☐ **Assessment of Autism Spectrum Disorder (ASD)**
☐ **Consultation**

Send completed document to Adult Autism Diagnostic Clinic, Glenrose Rehabilitation Hospital, 10230 111 Avenue, Edmonton, AB T5G 0B7, **Phone**: 780.735.8852, **Fax**: 780.735.6230

By submitting this referral, you are agreeing to participate in shared care for this individual. You have also explained your concerns to the patient/guardian(s).

Patient Information				
Last Name		First Name		
Name at birth if different from above	Date of Birth *(yyyy-Mon-dd)*	Gender ☐ Male ☐ Female		PHN
Address	City	Province	Postal Code	Phone

Patient lives *(check all that apply)*
☐ Alone ☐ with Spouse ☐ with Parent ☐ with Sibling ☐ with Extended family
☐ with Non-family ☐ in Group Home, provide name contact _____

Relationship status
☐ Single ☐ Married ☐ Common-law ☐ Divorced

Legal Guardian Information	
Name	Relationship
Alternate Phone *(If different from above)*	☐ Full guardianship ☐ Co-decision making

Is an interpreter required
☐ No ☐ Yes ➔ What Language? _____

Government Sponsored Funding/Services *(if applicable)*		
Program	Name of Worker	Phone

Referral Concerns and History ***(To be completed by Physician)***

Describe your concerns in as much detail as possible *(daily living, social functioning, vocational, emotional issues)*. Use additional pages as needed

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Referral Concerns and History *(To be completed by Physician)* continued

Co-morbid Medical Concerns *(check all that apply)*

- ☐ GI
- ☐ Sleep
- ☐ Seizures
- ☐ Substance use
- ☐ Mental health *(e.g. depression, anxiety, OCD, mania, suicidal ideation)*
- ☐ Sensory issues
- ☐ Other: _____

Current Medication *(Include dose and frequency, start date, who prescribed, effectiveness)*

1 _____

2 _____

3 _____

4 _____

5 _____

Behavioural Concerns *(check all that apply)*

- ☐ Aggression
- ☐ Self-Injury
- ☐ Relationship difficulty
- ☐ Self-help (independence) skills
- ☐ Over-activity or Inattention
- ☐ Preoccupations
- ☐ Self stimulatory behaviours *(e.g. rocking, spinning, flapping hands, visual scrutiny)*
- ☐ Sensory issues
- ☐ Other: _____

Referring Physician Information

Name & Address Stamp of Referring Physician
(must be legible, include PRACID#, office phone and fax number)

or fill out below

Name	Address	
PRACID	Phone	Fax