Autism Spectrum Disorder Family Support Program
REFERRAL FORM

The Autism Spectrum Disorder (ASD) Family Support Program provides community-based supports for children and youth ages 8-17 who have a diagnosis of Autism Spectrum Disorder (Level 1) for successful community integration and transitions.

Program Goals:

- To assist children and youth as they transition through elementary school to high school;
- To develop a partnership with families to help stabilize children and youth both at home and in the community;
- To provide and support with system navigation;
- To promote/preserve the emotional health of children, youth and their family;
- To support families in enhancing and strengthening existing parenting skills;
- To support and enhance parental advocacy skills to help families develop relationships within their larger community;
- To support children and youth in developing self-advocacy and other skills.

Eligibility Criteria:

- ✓ A diagnosis of High Functioning Autism (Autism Spectrum Disorder – Level 1);
- ✓ Between the ages of 8 and 17; and
- ✓ Must be a resident of Oxford or Elgin County.

To access this program, please complete this referral form and send it to Wellkin Child & Youth Mental Wellness, via email or fax:

Email: ASD@wellkin.ca

Fax: 519-539-7058

If you have any questions about the referral process or eligibility criteria, please call 1-877-539-0463.

REFERRAL INFORMATION

Referral Date:	Region - Oxford or Elgin County:
Referral Source - Self/Family or Service Provider:	
For Service Provider Referrals	
Agency:	Worker:
Telephone:	Email:
Please include a signed Consent to Exchange Information form along with this referral. *Note: For youth ages 12 and older, consent must be obtained from the youth. For children/youth under than 12 years old consent must be obtained by the youth as well as the parent/caregiver.*	

Form Updated January 26, 2022

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Child/Youth Information

Name:		Address:
Date of Birth:		City:
Age:	Gender:	Postal Code:

Parent/Caregiver Information

Name:	Relationship to Child/Youth:

Contact Information

Telephone:	Is it ok to leave a voice mail message?
Email:	
Who should Wellkin contact about this referral? Youth or Caregiver:	
Note: For youth ages 12 and older, consent for service must be obtained from the youth. For children/youth under than 12 years old consent must be obtained by the youth as well as the parent/caregiver.	

Diagnosis

A diagnosis of High Functioning Autism (Autism Spectrum Disorder – Level 1) is an eligibility criterion for accessing the ASD Family Support Program. Families will be screened for program eligibility and will be asked to provide medical/psychological assessment reports that confirm the diagnosis.

Is a medical/psychological assessment report attached? Yes/No: _____

Current Resources

Please provide a detailed overview of services you/the family is currently receiving from other agencies/ workers.

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Service Goals

Please provide a description of what services you need and are hoping for from this program? For example: What would be most helpful? What are the needs of the child/youth? What are the needs of the parent(s)/caregiver(s)?

Please Note: **There may be a wait list for this service. Our team will process referrals as soon as possible and we will contact you to set up an intake appointment once the referral has been assigned to our ASD Support Worker.**