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
- ✓ 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.**

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REFERRAL INFORMATION

Date Referral Completed: _____	Region: ☐ Oxford County ☐ Elgin County
Referral Source: ☐ Self/Family ☐ Service Provider	
For Service Provider Referrals	
Agency: _____	Worker: _____
Telephone: (_____) _____ - _____	Email:_____
Please include a signed consent to exchange information along with this referral form. **Note:** *Consent must be obtained from all children and youth participating in the service.*	

Child/Youth Information

Name:_____	Address: _____
Date of Birth: _____ YYYY/MM/DD	City: _____ Postal Code: _____
Age: _____	Gender: _____

Parent/Caregiver Information

Name: _____	Relationship to Child/Youth:_____

Contact Information

Telephone: (_____) _____ - _____	Is it okay to leave a voicemail message? _____
Email: _____	

Form Updated: December 20, 2022

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Who should Wellkin contact about this referral? Youth/Caregiver:_____
NOTE: *All children and youth must consent to participating in the service.*

Diagnosis

A diagnosis of Autism Spectrum Disorder – Level 1 is an eligibility criteria 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. Please include a copy of the diagnostic report/assessment along with this form.

Is a medical/psychological assessment report attached? ☐ **Yes** ☐ **No** ☐ **Not available** ☐ **No diagnosis**

Current Resources

Please provide a detailed overview of services the child/youth/family are currently receiving from other agencies or workers:

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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 the ASD Worker.**