Hamilton Health Sciences

Autism Spectrum Disorders (ASD) Diagnostic HUB Referral Form

Ron Joyce Children's Health Centre
237 Barton Street East, Hamilton, ON L8L 2X2
Phone: (905) 521-7950 Fax: (905) 577-8029

Child's Last Name _____ First Name _____

Address _____

City _____ Postal Code _____

HIN _____ Version Code _____ Date of Birth: (yyyy/mm/dd) _____

PLEASE PRINT CLEARLY

Date of Request: (yyyy/mm/dd) _____ **Date Last Seen:** (yyyy/mm/dd) _____

Referral Source: Name _____ Address: _____

Phone: _____ Fax: _____ Email: _____

If Physician: Signature _____ OHIP Billing Number _____

Family Physician: _____ Phone: _____

Substitute Decision Maker / Legal Guardian:

Name	**Relationship to Patient**	**Contact Number**	**Best time to call**
_____	☐ Parent ☐ Other - _____	_____	☐ a.m. ☐ p.m.
_____	☐ Parent ☐ Other - _____	_____	☐ a.m. ☐ p.m.

Do you required an Interpreter? ☐ No ☐ Yes – what language? _____

Reason for Referral: (Please include most recent assessment of the child and any other relevant documentation)

_____

_____

_____

_____ ☐ Query Autism

Other professionals/services currently involved: ☐ **CAS** ☐ **CCAS** ☐ **Other:** _____

_____

Other relevant diagnoses, conditions: _____

_____

_____ ☐ Current Allergy List faxed with Referral

Relevant medical / psychiatric / safety concerns regarding the family: _____

_____

_____

Please fax legibly completed form and any accompanying documentation to (905) 577-8029. Incomplete forms will be returned to the referral source. Families will be contacted directly to book their appointment.

Hamilton Health Sciences

For Internal Use Only – Pt. ID Number _____

CONSENT TO DISCLOSE PERSONAL AND / OR PERSONAL HEALTH INFORMATION – BIDIRECTIONAL

I _____, hereby authorize Hamilton Health Sciences
(Print Name)

Corporation to **Disclose personal information** *(which may include health information)* **to**:

Autism Spectrum Disorder (ASD) Diagnostic Hub - West Region, affiliated partners

- **LaRose Psychology Corp**
- **McMaster Children's Hospital**
- **Children First**
- **Grey-Bruce Health System**
- **Lansdowne Children's Centre**
- **Contact Niagara**
- **Thames Valley Children's Centre**
- **Child and Parent Resource Institute (CPRI)**
- **Pathways Health Centre for Children**
- **Children's Treatment Centre of Chatham-Kent**
- **Niagara Peninsula Children's Centre**
- **Dr. Melanie Freeman- Kaleidoscope Child and Family Care**

(Detailed partner information on page 2)

From the records of: _____ Date of Birth: _____
(Print name of patient) *(year / month / day)*

Health Card Number _____ Phone Number: _____

The type of personal information to be disclosed is:

_____ .

I understand that this personal (health) information is to be used only by the recipient for the purposes of: _____ .

I also authorize Hamilton Health Sciences Corporation to **Obtain personal information** *(which may include health information)* **from** the same individual / organization as indicated above.

The type of personal information to be obtained is:

_____ .

I understand that this personal (health) information is to be used only by Hamilton Health Sciences for the purposes of: _____

_____

I hereby waive any and all claims against Hamilton Health Sciences Corporation in connection with the disclosure of this personal and/or personal health information.

I have read and understood the information above, and the purpose of information sharing. I understand that I can withdraw my consent at any time.

_____	_____	_____
(year / month / day)	*Printed Name of Patient or Substitute Decision Maker*	*Signature of Patient or Substitute Decision Maker*

Witness Printed Name _____ _____

Witness Signature _____

If substitute decision maker, specify relationship to patient
and complete information on reverse

This form is valid for the purposes described above, for the duration that the patient is being cared for at Hamilton Health Sciences (program / service) _____ , **but not to exceed 12 months from the date of signing.**

Hamilton Health Sciences

For Internal Use Only – Pt. ID Number _____

CONSENT TO DISCLOSE PERSONAL AND / OR PERSONAL HEALTH INFORMATION – BIDIRECTIONAL

Date: (yyyy/mm/dd) _____ **RE:** Patient Name: _____

Substitute Decision Maker Identification

Name: _____

Address and Phone Number: _____

_____

Relationship to Patient: _____

1. I am at least 16 years old or I am under 16 years and the parent of the incapable patient

2. I believe that the incapable patient, when capable, would not have objected to me deciding about the disclosure of health information.

3. I believe that no one ranking higher than me, or the same rank as me, claims authority and is available and willing to decide about the disclosure of personal health information.

Choose one of the following:

a) Court Appointed Guardian
b) Power of Attorney
c) Representative appointed by the Consent Capacity Board
d) Spouse or Partner
e) Parent or Child
f) Parent with a right of access
g) Brother or sister
h) Any other relative related by blood, marriage or adoption

Date (yyyy/mm/dd) _____ Signature of Substitute Decision Maker _____

STATEMENT BY INTERPRETER: I have done my best to accurately translate this form for the person requesting the release of information.

_____ _____ (____) _____

Printed Name Signature Phone Number

Autism Spectrum Disorder (ASD) Diagnostic Hub - West Region affiliated partners

- **Child and Parent Resource Institute (CPRI)**
  Ministry of Children, Community and Social Services
  600 Sanatorium Rd., London, ON, N6H 3W7
- **Children First**
  2565 Ouellette Ave, Suite 105, Windsor, Ontario N8X 1L9
- **Children's Treatment Centre of Chatham-Kent**
  355 Lark Street, Chatham, ON, N7L 5B2
- **Contact Niagara**
  (Intake for Bethesda, services for children over 6 years) 3 Hanover Dr. #8, St. Catharines, ON, L2W 1A3
- **Dr. Melanie Freeman- Kaleidoscope Child and Family Care**
  363 Baldoon Rd., Unit 200, Chatham, ON, N7L 0C1
- **Grey-Bruce Health System**
  1800 8th St. East, Owen Sound, ON, N4K 6M9
- **Lansdowne Children's Centre**
  39 Mt Pleasant St., Brantford, ON, N3T 1S7
- **LaRose Psychology Corp**
  1615 N Routledge Park, Unit 35, London, ON, N6H 5N5
- **McMaster Children's Hospital,**
  Ron Joyce Children's Health Centre site
  325 Wellington St. North, Hamilton, ON, L8L 0A4
  Phone: 905 521-2100 X-78222, Fax: 905 577-8029
- **Niagara Peninsula Children's Centre,**
  (children under 6 years)
  67 Glenridge Ave., St. Catharines, ON, L2T 4C2
- **Pathways Health Centre for Children**
  1240 Murphy Road, Sarnia, ON, N7S 2Y6
- **Thames Valley Children's Centre**
  779 Base Line Rd. East, London, ON, N6C 5Y6

(Patient / SDM is to keep a copy of this consent upon completion)