{ Mind Science CONSULTANTS INC }
Dr Elizabeth Hartney
Licensed & Registered Psychologist

ASSESSMENT REFERRAL (Non-BCAAN)
For Autism Spectrum Disorder

Dear Referral Source,

Please find enclosed the **Assessment Referral Form for Autism Spectrum Disorder** (Non-BCAAN).

Dr Hartney provides diagnostic assessments for children, youth, and adults (ages 18 months – 21 years). We accept referrals from Family Practitioners, Pediatricians, Psychiatrists, Nurse Practitioners, Psychologists, Counsellors, and Speech-Language Pathologists.

Please include the required documents in order for us to process your referral in an appropriate and timely manner:

- Include a fully completed referral form.
- Include a detailed consult letter supporting the request for referral, which should identify historical and current behaviours and concerns in the areas of social communication, restricted interests, and repetitive behaviours. Please outline the patient's significant difficulties in multiple areas of functioning (such as development, cognition, learning, social skills, adaptive skills, mood, behaviours).
- Confirmed or suspected exposure to substances must also be included.
- Include any consults, birth records, and other reports you have on file that support the referral.

Urgent Processing Criteria
A request for an assessment is typically categorized as urgent if it is directly linked to circumstances such as:

- Risk to physical safety or risk of self-harm.
- Risk of entering the child welfare system due to lack of immediate support.
- Caregivers fleeing domestic violence who require immediate intervention for the child.
- Foreseeable risk of "irremediable harm" if the assessment or resulting service is delayed.

Please clearly indicate in your letter how the assessment addresses the patient's immediate unmet needs and the specific risks of delay:

Should you require additional information, call 604-355-7893.

Sincerely,

Elizabeth Hartney, PhD
Licensed & Registered Psychologist

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* For URGENT/EMERGENT Mental Health referrals, please refer to appropriate services(s)*

SUPPORTING DOCUMENTATION should include:

☐ Your consult letter outlining areas of significant concerns or difficulties

☐ Page 2 of referral concerns

☐ Other consultations (if available) from: ☐ IDP ☐ SLP ☐ OT/PT ☐ Psychology ☐ Other: _____

PATIENT INFORMATION (please print) REFERRAL DATE: _____

Child's name: *(Last)* _____ *(First)* _____ *(Middle)* _____

Date of birth *(yyyy/mm/dd):* _____ BC PHN#: _____ ☐ Male ☐ Female ☐ Other _____

Address where child lives: _____ *(City)* _____ *(PC)* _____

Phone numbers: *(Home)* _____ *(Work)* _____ *(Other)* _____

Child lives with: ☐ Mother ☐ Father

☐ Alternate/Foster Name: _____

Phone numbers: (*Home)* _____

(Work1) _____ *(Work2)* _____

(Cel 1) _____ *(Cel 2)* _____

(Other) _____

Legal Guardian's name & address *(if different from above)*

Name: _____

Address: _____

(City) _____ *(PC)* _____

☐ MCFD ☐ Other: _____

Day phone: _____ Other phone: _____

Interpreter needed? ☐ Yes ☐ No If yes, what language(s)?

PRIMARY REASON(S) FOR REFERRAL

☐ **Developmental delay** ☐ **Social-emotional functioning** ☐ **Activites of daily living**

Is the LEGAL GUARDIAN aware of the primary reason for referral? ☐ Yes ☐ No Why not? _____

Please specifiy:

_____

_____

Is hearing a concern? ☐ Yes ☐ No If yes, has hearing test been ☐ Initiated ☐ Completed

Is vision a concern? ☐ Yes ☐ No If yes, has vision test been ☐ Initiated ☐ Completed

Known Medical Diagnoses (including genetic disorders, physical impairments, etc): _____

_____

_____

_____

PHYSICIAN INFORMATION

Referring Physician's Name: *(Last)* _____ *(First)* _____ BC MSC # _____

☐ Pediatrician ☐ Family Practitioner ☐ Psychiatrist ☐ Othert: _____

Address: _____

Phone #s: _____ Fax #s: _____

Signature (mandatory) _____

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Please indicate if you have concerns about the following:

- ☐ **Development, Cognition, and Learning** – developmental history and current concerns
- ☐ **Adaptive and Social Skills** – self care, interpersonal skills, safety, etc.
- ☐ **Mental Health and Behaviour** – regulation, attention, mood, etc.
- ☐ **Bio Markers** – documented or substantiated evidence of exposure to environmental agents including alcohol. Dysmorphic features, suspected syndrome or observable abnormalities.

Additional Comments:

_____

_____

_____

_____

_____

We provide diagnostic assessments for those with **suspected Autism Spectrum Disorder** and accept referrals from **all physicians**.

Please indicate if you have concerns about the following:

☐ Mental Health/Behaviour ☐ Cognition/Developmental Delay ☐ Language

Please indicate your level of concern in each domain and provide examples of behaviours that support it:

Social Communication	**Repetitive Behaviours**
☐ Unknown/no concern	☐ Unknown/no concern
☐ Level 1 - noticeable impairments in social communication; difficulty initiating social interactions.	☐ Level 1 - noticeable inflexibility of behaviours cause significant interference with functioning.
☐ Level 2 - moderate deficits in verbal and nonverbal social communication; limited initiation of social interactions; reduced response to social overtures.	☐ Level 2 - moderate inflexibility of behavior; difficulty coping with change; obvious repetitive behaviours cause impairment in functioning.
☐ Level 3 - severe impairment in functioning; severe impairment in verbal and nonverbal social communication; difficulty initiating social connections; not responding to social overtures; inability to make friends; disconnected conversations.	☐ Level 3 - severe inflexibility or repetitive behaviours cause significant functional issues; difficulty changing focus; extreme difficulty coping with change.
Examples: _____	Examples: _____
_____	_____

Who is concerned about these behaviours? ☐ Guardian ☐ School ☐ Other professional (i.e. SLP, OT)_____

Attach copies of all documents that support this referral (i.e. school or daycare reports, speech and language reports, IDP reports).

Please e-mail Referral Form (Page 1 and 2) and **send copies of all relevant letters, consults, reports, and medical investigations to**: drhartney@mindscience.ca