BRITISH COLUMBIA | Ministry of Children and Family Development

AUTISM PROGRAMS

CONFIRMATION OF PREVIOUS DIAGNOSIS OF AUTISM SPECTRUM DISORDER

The personal information collected on this form will be used for the purposes of determining eligibility for Ministry Autism Programs and will be treated confidentially in compliance with the *Freedom of Information and Protection of Privacy Act*. Any questions about the collection, use or disclosure of this information should be directed to the Children and Youth Special Needs Policy Branch, (250) 952-6044, PO Box 9719 Stn Prov Govt, Victoria, B.C. V8W 9S1.

This form is to be completed for:

1. BC Residents with a child under the age of 19 who was diagnosed with Autism Spectrum Disorder (ASD) prior to April 01, 2004.
2. New BC Residents with a child under the age of 19 who was diagnosed with ASD in another province, territory or from outside of Canada.

COMPLETED FORM TO BE RETURNED TO YOUR LOCAL MCFD OFFICE

PART ONE - TO BE FILLED OUT BY PARENT OR GUARDIAN

CHILD'S NAME	DATE OF BIRTH (YYYY/MM/DD)	CURRENT BC CARE CARD NUMBER
PARENT/GUARDIAN'S NAME	HOME TELEPHONE NUMBER ( )	WORK TELEPHONE NUMBER ( )
BC ADDRESS	CITY/TOWN	POSTAL CODE

I consent to release this information to the Ministry of Children and Family Development for the purpose of determining eligibility for Autism Funding: Under Age 6; Autism Funding: Ages 6-18; and Early Intensive Behaviour Intervention Program (EIBI). I understand that additional information may be requested and shared with British Columbia Autism Assessment Network (BCAAN). This information will be treated confidentially and in compliance with the *Freedom of Information and Protection of Privacy Act*.

SIGNATURE OF PARENT OR GUARDIAN COMPLETING FORM

DATE SIGNED (YYYY/MM/DD)

PART TWO – TO BE FILLED OUT BY A QUALIFIED BC SPECIALIST

SECTION 1 – QUALIFIED BC SPECIALIST INFORMATION

NAME OF SPECIALIST COMPLETING FORM	PLEASE CHECK DISCIPLINE ☐ Paediatrician ☐ Psychiatrist ☐ Registered Psychologist		
WORK ADDRESS	CITY/TOWN	PROVINCE/TERRITORY	POSTAL CODE
TELEPHONE NUMBER ( )	FAX NUMBER ( )	EMAIL ADDRESS	COLLEGE ID

SECTION 2 – CONFIRMATION OF DIAGNOSTIC INFORMATION

DOES THE CHILD HAVE ASD*? ☐ YES ☐ NO	DATE OF DIAGNOSIS (YYYY/MM/DD)	LOCATION (CITY/PROVINCE/TERRITORY/COUNTRY)
DIAGNOSIS OF ASD* FULFILLS CRITERIA OF DSM-IV-TR/ICD-10? ☐ YES ☐ NO		

*Includes: Autistic Disorder; Asperger's Disorder; Pervasive Development Disorder – Not Otherwise Specified (PDD-NOS); and Rett's & Childhood Disintigrative Disorder (CDD).

SECTION 3 – INTERVENTION OPTIONS

Based upon the documentation and assessment of the child are there specific deficits associated with ASD that would be alleviated by treatment or intervention?	☐ YES ☐ NO

SECTION 4 – AREAS OF GREATEST CONCERN WHICH MAY BENEFIT FROM INTERVENTION

Please check all applicable boxes:

DOMAIN	INTERVENTION OPTIONS
☐ **SOCIAL ADJUSTMENT‡** (e.g.: peers, school, community)	• Behavioural Support Consultation/Intervention • Discrete Trial/Structured Teaching/ABA Therapy • Individual/Group Counselling/Therapy • Life Skills Training • Social Skills Training (Group or Individual)
☐ **PROBLEM BEHAVIOURS‡** (e.g.: stereotyped/disruptive/self-injurious behaviours, aggression, conduct)	• Augmentative Communication Consultation/Intervention • Behavioural Support Consultation/Intervention • Dietician/Nutrition Consultation/Support • Discrete Trial/Structured Teaching/ABA Therapy • Family Counselling/Therapy • Individual/Group Counselling/Therapy • Learning Support/Tutoring • Life Skills Training • Occupational Therapy/Consultation/Intervention • Physiotherapy Consultation/Intervention • Social Skills Training (Group or Individual) • Speech and Language Pathology Consultation/Intervention
☐ **EMOTIONAL FUNCTIONING‡** (e.g.: mood, anxiety, inattention, thought problems, compulsions, etc.)	• Behavioural Support Consultation/Intervention • Individual/Group Counselling/Therapy • Social Skills Training (Group or Individual)
☐ **COMMUNICATION** (e.g.: receptive, expressive, pragmatic, stereotypical, language)	• Augmentative Communication Consultation/Intervention • Discrete Trial/Structured Teaching/ABA Therapy • Speech and Language Pathology Consultation/Intervention
☐ **ACADEMIC PROBLEMS** (e.g.: achievement, learning difficulties, independence)	• Augmentative Communication Consultation/Intervention • Behavioural Support Consultation/Intervention • Discrete Trial/Structured Teaching/ABA Therapy • Learning Support/Tutoring • Occupational Therapy/Consultation/Intervention • Speech and Language Pathology Consultation/Intervention
☐ **MOTOR/SENSORY FUNCTIONING** (e.g.: gross motor, fine motor, and sensory system)	• Discrete Trial/Structured Teaching/ABA Therapy • Occupational Therapy Consultation/Intervention • Physiotherapy Consultation/Intervention
☐ **HEALTH/GROWTH** (e.g.: nutrition)	• Dietician/Nutrition Consultation/Support • Speech and Language Pathology Consultation/Intervention • Occupational Therapy Consultation/Intervention
☐ **FAMILY FUNCTION** (e.g.: parent and sibling adjustment, stressors, safety)	• Behavioural Support Consultation/Intervention • Family Counselling/Therapy • Individual/Group Counselling/Therapy
☐ **LIFE SKILLS** (e.g.: feeding, dressing, hygiene, independence, safety)	• Behavioural Support Consultation/Intervention • Discrete Trial/Structured Teaching/ABA Therapy • Life Skills Training • Occupational Therapy Consultation/Intervention

‡ DEFICITS IN THESE DOMAINS SHOULD PROMPT THE CLINICIAN TO SEARCH FOR UNDERLYING PROBLEMS IN ALL OTHER DOMAINS

I agree that the above intervention options will alleviate the features of autism as identified in the above domains. **I have reviewed and attached the original assessment and diagnostic report(s).**

SIGNATURE OF SPECIALIST COMPLETING FORM

DATE SIGNED (YYYY/MM/DD)