BRITISH COLUMBIA | Ministry of Children and Family Development

AUTISM PROGRAMS

NON-BCAAN (PRIVATE) 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 Support 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 who have a child under the age of 19 and has received a diagnosis of Autism Spectrum Disorder (ASD) in BC from a Non-BCAAN clinician/team after March 31, 2004.
2. The Diagnosis and assessment must adhere to the standards and guidelines for diagnosing Autism Spectrum Disorder found at: http://www.health.gov.bc.ca/library/publications/year/2003/asd_standards_0318.pdf

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 SPECIALIST - Must be complete and legible

SECTION 1 – QUALIFIED SPECIALIST INFORMATION - must be completed by a professional who is registered with a BC College in one of the disciplines listed below and who has been trained in the use and administration of ADOS and ADIR.

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/REGISTRATION NUMBER or MSP number for College of Physicians
( )	( )		

SECTION 2 – CONFIRMATION OF DIAGNOSTIC INFORMATION

DOES THE CHILD HAVE ASD*? ☐ YES ☐ NO	DATE OF DIAGNOSIS(YYYY/MM/DD)	LOCATION (CITY/PROVINCE/TERRITORY)
DIAGNOSIS OF ASD* FULFILLS CRITERIA OF DSM-IV-TR/ICD-10? ☐ YES ☐ NO Next version will update to clarify that criteria must meet DSM-V		

HISTORICAL TOOL USED IN ASSESSMENT** ☐ ADI-R	NAME OF PERSON WHO ADMINISTERED TOOL	DATE OF ADMINISTRATION(YYYY/MM/DD)
OBSERVATIONAL TOOL USED IN ASSESSMENT** ☐ ADOS	NAME OF PERSON WHO ADMINISTERED TOOL	DATE OF ADMINISTRATION(YYYY/MM/DD)

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

**For ASD diagnosis in BC, both the ADOS and ADIR are required instruments.

NOTE: The Qualified Specialist completing the form and providing the final diagnosis must have completed at least one of the diagnostic tools.

SECTION 3 – REQUIRED DOCUMENTATION

Please provide a copy of each of the following reports, where applicable: Check each applicable box and provide full and complete copies.

☐ ASSESSMENT AND DIAGNOSTIC REPORT FOR CHILDREN OVER THE AGE OF 6		
☐ PSYCHOLOGICAL ASSESSMENT FOR CHILDREN UNDER THE AGE OF 6	NAME OF PSYCHOLOGIST	DATE OF ASSESSMENT(YYYY/MM/DD)
☐ PAEDIATRIC ASSESSMENT FOR CHILDREN UNDER THE AGE OF 6	NAME OF PAEDIATRICIAN	DATE OF ASSESSMENT(YYYY/MM/DD)
☐ SPEECH LANGUAGE PATHOLOGY (SLP) FOR CHILDREN UNDER THE AGE OF 6	NAME OF SLP	DATE OF ASSESSMENT(YYYY/MM/DD)

SECTION 4 – INTERVENTION OPTIONS

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

SECTION 5 – PROFESSIONAL RECOMMENDATIONS

Please check all applicable boxes: Must complete all that apply.

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

Physical signature

SIGNATURE OF QUALIFIED SPECIALIST COMPLETING FORM AND PROVIDING FINAL DIAGNOSIS
(MUST HAVE ADMINISTERED AT LEAST ONE OF THE DIAGNOSTIC TOOLS)

DATE SIGNED(YYYY/MM/DD)