Provincial Preschool Autism Service
Send completed referrals by fax or email:
Phone: 1-833-200-7817
Fax: 902 428-9931
referrals-preschoolautism@iwk.nshealth.ca

PROVINCIAL PRESCHOOL AUTISM SERVICE
DIAGNOSTICS AND INTAKE FORM

*Use this form to refer any child residing in Nova Scotia who is **not yet in Grade Primary** to PPAS for autism services. If you are **not** currently seeking an autism diagnostic assessment in addition to other PPAS services, please complete the Provincial Preschool Autism Service Intake Form.*

PPAS Clinical Intake and Care Coordination matches to all PPAS services (see PPAS Handout):

Autism Diagnostics, QuickStart Nova Scotia, Communication Services, Focused Intervention, Early Start Denver Model-Informed Service, Intensive Service, Foundational Education, and Care Coordination and Navigation. PPAS's Clinical Intake and Care Coordination Team will contact the family to **schedule an intake appointment** and match the child to services based on eligibility, child needs, and family priorities.

SELECT ONE:
☐ **New Autism Diagnostic Assessment**
☐ **Autism Diagnostic Reassessment** (please describe)

Name of Child:	(given name/s)	(surname/s)	**Date of Birth:**	(dd/mm/yyyy)
Health Card No.:		**IWK Unit#:** (if applicable)		
Primary Address: (include postal code)		**Secondary Address:** (If applicable)		
Family Physician/ Nurse Practitioner:		**Pediatrician: (If applicable)**		

Caregiver:		**Relationship to child:**	
Email:		**Phone:**	
Caregiver:		**Relationship to child:**	
Email:		**Phone:**	

☐ **Caregiver provides consent for email communication**			
Does the family require assistance in completing forms? *(i.e., reading/comprehension challenges, language barriers)*	☐ **Yes** ☐ **No** ☐ **Unclear**		
Need for interpreter:	**Caregivers:** ☐ **Yes** ☐ **No** ☐ **Unclear**	**Child:** ☐ **Yes** ☐ **No** ☐ **Unclear**	
Any special considrations for this child/family: *(e.g., new Canadians, languages spoken at home, existing diagnoses).*			

Please continue to Page 2 to complete the full referral form.

Signs of Autism:

Please complete both boxes below.

A) SOCIAL-COMMUNICATION AND INTERACTION
Please describe any differences in: • **social-emotional reciprocity** *(e.g., approaching and responding to others, sharing interests and enjoyment, having back and forth conversations)* • **nonverbal communication** *(e.g., pointing, eye contact, responding to name)* • **play and social interaction** *(e.g., seeking out children of the same age, pretend play)*
Have you observed any of these social social-communication differences? Yes ☐ No ☐ If not, indicate who reported these behaviours to you:
B) RESTRICED, REPETITIVE PATTERNS OF BEHAVIOUR, INTERESTS, OR ACTIVITIES
Please describe any: • **stereotyped or repetitive motor movements, use of objects, or speech** *(e.g., hand flapping, lining up toys, repeating others' speech)* • **significant difficulty coping flexibly** *(e.g., distress at small changes, clear upset when routines change)* • **intense, focused interests** *(e.g., extremely strong interests, unusual interests)* • **clear sensory differences** *(e.g., very strong response to certain sounds or textures, frequent smelling or touching of objects, looking at objects very closely)*
Have you observed any of these behaviours? Yes ☐ No ☐ If not, indicate who reported these behaviours to you:
☐ **Check and describe if supporting documentation is attached:**
Other comments:

If this referral is being completed by a professional, complete the section below:

Name of referral source:		**Profession:**	
Phone:		**Email:**	

Signature of referral source: _____ **Date:**

Signature by the referral source indicates parent/guardian has consented to this referral being sent to the Preschool Autism Team. All referrals are placed on the IWK Health Record.