PROVINCIAL PRESCHOOL AUTISM SERVICE

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 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 seeking an autism diagnostic assessment in addition to other PPAS services please complete the Preschool Diagnostic and Intake Referral Form. Only one referral form is required.*

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.

CHILD INFORMATION:			
Name of Child:	(given name/s) (surname/s)	**Date of Birth:**	(dd/mm/yyyy)
Health Card No.:		**IWK Unit#:** (if known)	
Primary Address: (include postal code)		**Secondary Address:** (If applicable)	
Family Physician/ Nurse Practitioner:		**Pediatrician (where 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 considerations for this child/family: *(e.g., new Canadians, languages spoken at home, existing diagnoses).*			
☐ **Check and describe if supporting documentation is attached:**			

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.