DEVELOPMENTAL SERVICES
RESOURCE CENTRE
WATERLOO REGION

205 - 1120 Victoria St. N., Kitchener, ON N2B 3T2
Tel: 519-741-1121 Fax: 519-743-4730
Toll-free: 1-888-941-1121 www.dscwr.com

**General Information:**

Please find enclosed the material you will need in order to make a referral to the Developmental Services Resource Centre – Waterloo Region. We offer clinical assessment, consultation and support services to individuals who have a developmental disability and/or an autism spectrum disorder, and to their family and support agencies. There is no fee for the individual user.

**Eligibility:**

The services of the Developmental Services Resource Centre team are available to individuals of any age who have a developmental disability and/or an autism spectrum disorder.

A referral can be made by the individual, the family, the family doctor, or any agency acting on the family's behalf; but can only be accepted with the client's/family's signed consent.

Consent forms need to be signed by clients 16 years of age or older if they are able to understand the implications of assessment/treatment.

If you have concerns or questions about our agency's policies regarding eligibility for children, under 18 years of age, please contact our Clinical Intake Worker. Eligibility for adults, 18 years or older, is determined by Developmental Services Ontario.

**What Happens Next?**

After receiving the completed forms, you will be contacted to arrange an appointment to meet. This phone contact should occur within 2 to 4 weeks. If you have not heard from us in that time, please call 519-741-1121, so that we can avoid any unnecessary delays.

Thank you for your referral to our agency. We look forward to working with you.

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# CLIENT REFERRAL FORM

**DATE RECEIVED:** _____ **Client ID #:** _____

## CLIENT INFORMATION

**CLIENT'S NAME:** _____
First Middle Last

**DATE OF BIRTH:** _____ **AGE:** _____ **SEX:** _____
(Month/Day/Year)

**CLIENT'S ADDRESS:** _____

_____

_____ **PHONE:** _____

## CONSENTS Signed By: Client ☐ or Legal Guardian ☐

**PARENT/GUARDIANS' NAME(S):** _____

**ADDRESS (if different from client's):** _____

_____

**CONTACT PERSON:** _____

**HOME PHONE:** _____ **WORK PHONE:** _____

**EMAIL ADDRESS:** _____

## REFERRAL SOURCE (if other than parent)

**REFERRED BY:** _____

**AGENCY/ADDRESS:** _____

_____ **PHONE:** _____

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## CURRENT NEEDS AND GOALS:

## HAS A PREVIOUS PSYCHOLOGICAL ASSESSMENT BEEN COMPLETED? ☐ YES ☐ NO

**MADE BY:** _____

**(If your child's school is facilitating your referral, please obtain a copy of their psychoeducational assessment to verify eligibility.)**

## DIAGNOSIS (if any)

_____

**MADE BY/POSITION:** _____

**AGENCY:** _____

## WHAT AGENCIES HAVE BEEN INVOLVED IN ADDRESSING THESE CONCERNS?

_____ _____

_____ _____

_____ _____

_____ _____

## PHYSICIAN

**NAME:** _____

**ADDRESS:** _____

_____ **PHONE:** _____

## FOR OFFICE USE ONLY

**INTAKE/REFERRAL DATE:** _____

**PREVIOUS CLIENT: Yes ☐ No ☐ PREVIOUS INVOLVEMENT:** _____

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**Client ID #:** _____

# CONSENT TO SHARE INFORMATION

I/We _____ hereby consent to
**Name of Parent/Guardian or Client (PLEASE PRINT)**

Developmental Services Resource Centre (DSRC) obtaining/releasing information pertaining to:

_____ _____
**Name of Client (PLEASE PRINT)** **Date of Birth**

From/to the following people/agencies:

| Name of Person/Agency | Initials | Name of Person/Agency | Initials |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

The purpose of sharing the information is to assist with planning on behalf of the client, and with accessing supports and services.

I know that I may withdraw my consent, in writing, at any time.

_____ _____
**Signature of Client and/or Parent/Guardian** **Date**

_____ _____
**Witness Signature** **Date**

**Please describe any limitations to this consent (Lockbox):**

_____
_____
_____



***Consent valid for five years from date of signing.***