DEVELOPMENTAL SERVICES
RESOURCE CENTRE
WATERLOO REGION

205 - 1120 Victoria St. N., Kitchener, ON N2B 3T2
Tel: 519-741-1121 Fax: 519-743-4730
Website: 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 contact should occur within 6 to 8 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: _____

PRIMARY PHONE: _____ **ALTERNATE PHONE:** _____

EMAIL ADDRESS: _____

REFERRAL SOURCE (if other than parent)

Referred By: _____

Agency/Address: _____

_____ **Phone:** _____

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CURRENT NEEDS AND GOALS:

DIAGNOSIS

Please check one of the following:

☐ **Intellectual Disability** ☐ **Autism Spectrum Disorder** ☐ **Both**

☐ **Meets Eligibility criteria for adult services by Developmental Services Ontario (DSO)**

DIAGNOSIS MADE BY/POSITION: _____

☐ **Assessments/Reports confirming eligibility are attached.**
(Please note that we cannot process this referral without documentation verifying eligibility.)

WHAT AGENCIES HAVE BEEN INVOLVED IN ADDRESSING THESE CONCERNS?

PHYSICIAN

Name: _____

Address: _____

_____ **Phone:** _____

FOR OFFICE USE ONLY

Intake/Referral Date: _____

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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.

_____ By initialing here, I am giving consent to share my/my child's information electronically.

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 one year from date of signing.