Contact NIAGARA
For Children's and Developmental Services
pour les services à l'enfances et d'adaptation

Physician Referral Form

Contact Niagara – The access point for children's developmental services including autism and FASD.
Our intake process will ensure your referral will be directed to the appropriate services.

FAX: 905-684-2728

Patient Name:		**Is Client 16+? Yes** ☐ **No** ☐	
DOB:		**Address:**	
Gender:		**City:**	
Client Phone:		**Postal Code:**	

Mother/Guardian Name:		**Primary Phone:**	
Father/Guardian Name:		**Alt Phone:**	
Resides with:			

Custody: **N/A** ☐ **Joint** ☐ **Sole** ☐ **Unknown** ☐

Family Physician:		**Physician Signature:**	
Physician Billing Number:			
Physician Phone:			

Referred by: _____ Date : _____

Reason for Request (Required):

☐ Pediatric assessment re: ASD
☐ Psychological assessment re: intellectual disability
☐ FASD Concerns
☐ Other Developmental Concerns

Additional Comments

Consent and Agreement

I/, WE (Client/Patient/Guardian) AGREE TO THE EXCHANGE OF INFORMATION BETWEEN

Name of Physician _____

AND CONTACT NIAGARA. I ALSO AGREE TO A RESOURCE COORDINATOR CALLING ME FOR THE PURPOSE OF COMPLETING AN INTAKE.

Signature of Client _____ Date _____