

General Information:

Please find enclosed the material you will need in order to make a referral to the Sunbeam Developmental Resource Centre. 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 Sunbeam Developmental 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 (DSO). For further information or to make a referral to DSO, please call 519-894-1153, Ext. 2910.

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.

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: _____



205 - 1120 Victoria St. N., Kitchener, ON N2B 3T2
Tel: 519-741-1121 Fax: 519-743-4730
Website: www.sdrc.ca

Client ID #: _____

CONSENT TO SHARE INFORMATION

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

Sunbeam Developmental Resource Centre (SDRC) 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):

