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

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 or their legal guardian. SDRC will also accept referrals from extended family members, family physicians, or any agency acting on the individual's/family's behalf, as long as permission to do so has been provided by the individual or their guardian.

The consent of individuals 16 years of age or older who are able to understand the implications of assessment/treatment is required when facilitating a referral on their behalf.

Documentation in the form of an assessment report/letter which confirms a diagnosis of an autism spectrum disorder and/or an intellectual disability is required. Please note that a letter simply stating a diagnosis without providing supporting assessment information is not sufficient to confirm eligibility for SDRC services

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). Please call 519-894-1153, Ext. 2906 or 2914 to make a referral to DSO.

What Happens Next?

After receiving a completed referral form and the required supporting documentation verifying eligibility for SDRC services, you will receive a Referral Confirmation letter by mail or email within 2 to 4 weeks. This will be followed by contact from an Intake worker to arrange an initial Intake Appointment. The wait for an appointment can vary depending on referral volumes and may take up to 6 months.

If you have not received a Referral Confirmation letter from us after 4 weeks, 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.

sunbeam
DEVELOPMENTAL RESOURCE CENTRE

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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)

Client/Parent/Guardian Permission Received to Facilitate this Referral: **Yes ☐** **No ☐**
(if No, Referral can not be accepted)

Referred By: _____

Agency/Address: _____

_____ **Phone:** _____

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DEVELOPMENTAL RESOURCE CENTRE

CURRENT NEEDS AND GOALS:

DIAGNOSIS

Please check one of the following:

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

☐ **Meets eligibility criteria for adult services through 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.)

PLEASE INDICATE ALL SUPPORTS/PROGRAMS CURRENTLY BEING ACCESSED/REFERRED TO:

☐ **Access2 Card**	☐ **ACSD**	☐ **Disability Tax Credit (DTC)**	☐ **Disability Travel Card**
☐ **Easter Seals Incontinence Grant**	☐ **Front Door/ Carizon**	☐ **GRT Card**	☐ **KidsAbility**
☐ **KW Habilitation**	☐ **Ontario Autism Program (OAP)**	☐ **PAL Card**	☐ **Special Services at Home (SSAH)**

FOR REFERRALS FACILITATED BY KIDSABILITY

This Referral is for Resource Support Only ☐ **Yes** ☐ **No**
(If **Yes,** child will be registered with SDRC and family is to contact SDRC for Resource Support when needing help)

FOR OFFICE USE ONLY

Intake/Referral Date: _____