AUTISM PROGRAMS
DIAGNOSIS OF AUTISM SPECTRUM DISORDER

The personal information collected on this form will be used for the purposes of determining eligibility for Autism Individualized Funding through the Ministry of Social Services and will be treated confidentially in compliance with the *Health Information Protection Act* and the *Freedom of Information and Protection of Privacy Act*. Any questions about the collection, use or disclosure of this information should be directed to the Ministry of Social Services, 1-833-304-1774.

This form is to be completed for:
Saskatchewan residents who have a child under the age of 12 who has received a diagnosis of Autism Spectrum Disorder (ASD) in order to access Autism Individualized Funding.

CHILD'S NAME:

DATE OF BIRTH: SASK HEALTH SERVICES NUMBER:

PARENT/GUARDIAN'S NAME:

SECTION 1 – QUALIFIED SPECIALIST INFORMATION

NAME OF SPECIALIST COMPLETING THE FORM: ☐

PLEASE CHECK DISCIPLINE:

- ☐ Pediatrician
- ☐ Physician (General Practitioner)
- ☐ Registered Psychologist
- ☐ Autism Spectrum Disorder Consul tant
- ☐ Registered Social Worker
- ☐ Psychiatrist

WORK ADDRESS: ☐

CITY/TOWN: ☐ POSTAL CODE: ☐

PROVINCE/TERRITORY: ☐

PHONE NUMBER: ☐ FAX NUMBER: ☐

EMAIL ADDRESS: ☐

COLLEGE ID/REGISTRATION NUMBER (IF APPLICABLE): ☐

SECTION 2 – AUTISM SPECTRUM DISORDER DIASGNOSIS INFORMATION (Please complete either 2a or b**.)**

2 a. CONFIRMATION OF DIAGNOSIS (To be filled in by the qualified specialist who provided the ASD diagnosis**)**

☐ PLEASE CHECK BOX IF THE CHILD HAS ASD ACCORDING TO CRITERIA OF **DSM-5/ ICD-10**

Date of Diagnosis: ______

2 b. REVIEW OF EXISTING DIAGNOSIS (To be filled in by qualified specialist* reviewing and can confirm the ASD diagnosis.

☐ PLEASE CHECK BOX IF YOU HAVE REVIEWED THE CHILD's PAST ASSESSMENTS AND CAN CONFIRM THE CHILD HAS RECEIVED A DIAGNOSIS OF ASD ACCORDING TO THE CRITERIA OF THE **DSM-5/ICD-10**

NAME OF QUALIFIED SPECIALIST REVIEWING THE DIAGNOSIS ______

LOCATION (CITY/PROVINCE/TERRITORY) ______

Date of Diagnosis: ______

NAME OF QUALIFIED SPECIALIST WHO PROVIDED DIAGNOSIS ______

LOCATION (CITY/PROVINCE/TERRITORY) ______

Date of Original Diagnosis: ______

SIGNATURE OF QUALIFIED SPECIALIST COMPLETING FORM ______

DATE SIGNED (yyyy/mm/dd) ______

PART THREE – TO BE FILLED OUT BY PARENT OR GUARDIAN

I consent to release this information to the Ministry of Social Services for the purpose of determining eligibility for Autism Individualized Funding. This information will be treated confidentially and in compliance with the *Health Information Protection Act* and the *Freedom of Information and Protection of Privacy Act.*

SIGNATURE OF PARENT OR GUARDIAN COMPLETING FORM ______

DATE SIGNED (yyyy/mm/dd) ______

PLEASE UPLOAD YOUR COMPLETED DIAGNOSTIC FORM TO YOUR APPLICATION FOR INDIVIDUALIZED FUNDING AVAILABLE AT autismfunding.saskatchewan.ca

If you are mailing in your application for individualized funding, please include this form.

* Pediatrician; Registered Psychologist; Physician (General Practitioner); Autism Spectrum Disorder Consultant; Registered Social Worker; Psychiatrist

* If you have questions please contact your ASD consultant or the Ministry of Health at info@health.gov.sk.ca or 1800 667 7766.