St.Amant	**St.Amant Autism Programs** Enhanced Consultative Services	Date Received: _____ Start Date: _____

STUDENT INFORMATION

Name:_____ Birth date: _____ Gender: _____
(First) (Middle) (Last) (Day/Month/Year)

Has the student previously participated in the St.Amant Autism Programs? Yes ☐ No ☐

If the student has not previously participated in the St.Amant Autism Programs, then they are not eligible for the individualized student support through Enhanced Consultative Services. However, school staff would still be able to access a variety of workshops and presentations offered through the Autism Programs.

Name of Student Services Administrator/Consultant
Making the referral: _____ Phone:_____

Name of school division in which the student belongs: _____

Name of school the student attends: _____Grade level: _____

School mailing address: _____
(Street / City / Postal Code)

School Principal Name:_____ School Phone #: _____

Student's Case Manager:_____ Position: _____ Email:_____

For which school year are you requesting support?_____

Have you discussed this referral with the student's parents/legal guardians? Yes ☐ No ☐

Parent (Legal Guardian) Names: *(please print)* _____

Parent (Legal Guardian) Phone: _____ Email: _____

Student's Home Mailing Address: _____

LANGUAGE PREFERENCE

In which of the two Canadian official languages would you prefer Consultative services? ☐ English ☐ French

REQUEST FOR SUPPORT

1. Is the student at imminent risk of harm/crisis? (i.e., harm to others or harm to themselves) Yes ☐ No ☐

REQUEST FOR SUPPORT – continued from page 1

2. Please select options for individualized student support:

- ☐ Challenging Behaviour (e.g., aggression towards staff/peers, self-injurious behaviours, disruptive behaviours that interfere with learning/social opportunities, etc.)

Please describe:

_____

_____

_____

- ☐ Identifying Skill Acquisition Goals (e.g., teaching communication skills, daily living skills, vocational skills, transitioning out of high school, transition to new school, toileting/incontinence, academic related tasks, social skills, working independently in the school setting, etc.)

Please describe:

_____

_____

_____

NAMES AND SIGNATURES

_____	_____
Signature – Student Services Administrator/Consultant	Signature – School Principal
_____	_____
Date (Day/Month/Year)	Date (Day/Month/Year)
_____	_____
Signature – Parent/legal guardian	Signature – Parent/legal guardian
_____	_____
Legal Guardian's Relationship to Child (if not parent)	Legal Guardian's Relationship to Child (if not parent)
_____	_____
Date (Day/Month/Year)	Date (Day/Month/Year)

For Administrative Use Only - Outcome:

Referral application complete: ☐ Date: _____

Date of communication to referring agent regarding the accepted referral: _____

Service Start Date: _____ Service End Date: _____

Autism Programs staff signature: _____

Notes/recommendations: _____

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