SUNNY HILL HEALTH CENTRE FOR CHILDREN
Provincial Autism Resource Centre
A part of Children's & Women's Health Centre of British Columbia
An academic health centre affiliated with the University of British Columbia
3644 Slocan Street, Vancouver, BC V5M 3E8
Phone: (604) 453-8300 Fax: (604) 453-8390

CHILD AND FAMILY FORM

Your child has been referred to the Provincial Autism Resource Centre.
To help us proceed with the referral, please complete this questionnaire.

DATE:_____ **SUNNY HILL CHART NUMBER:** _____

CHILD

NAME: _____ Birthdate: _____
FAMILY NAME FIRST NAME MIDDLE NAME DAY MONTH YEAR

ADDRESS: _____
STREET CITY PROVINCE POSTAL CODE

PRIMARY RESIDENCE: ☐ family home ☐ group home ☐ foster home ☐ other (please specify) _____

PARENT(S) or PERSON(S) WITH WHOM CHILD LIVES:

NAME: _____
FAMILY NAME FIRST NAME RELATIONSHIP

PHONE: _____ Cell: _____ WORK: _____
area code area code area code

EMAIL: _____

NAME: _____
FAMILY NAME FIRST NAME RELATIONSHIP

PHONE: _____ Cell: _____ WORK: _____
area code area code area code

EMAIL: _____

PARENT(S) or LEGAL GUARDIAN(S) ☐ SAME AS ABOVE

NAME: _____
FAMILY NAME FIRST NAME RELATIONSHIP

NAME: _____
FAMILY NAME FIRST NAME RELATIONSHIP

ADDRESS: _____
STREET CITY PROVINCE POSTAL CODE

PHONE: _____ WORK: _____
area code area code

CELL PHONE: _____ EMAIL: _____
area code

Language(s) spoken at home: _____

Parent/Guardian fluent in English? ☐ YES ☐ NO **Child fluent in English?** ☐ YES ☐ NO

Person we can contact who speaks English: _____
name and telephone number

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1. **What are your main concerns about your child?**

_____

_____

_____

_____

2. **Has your child been given a specific diagnosis?** ☐ YES ☐ NO

If **YES**, what is the diagnosis **AND** who provided the diagnosis? (NAME AND TELEPHONE NUMBER)

_____

_____

3. **Does your child attend:**

☐ Daycare – Name: _____

☐ Preschool – Name: _____

☐ Public School – Name: _____ Grade: _____

☐ Private School – Name: _____ Grade: _____

☐ Home School Grade: _____

4. **Has your child had a psychoeducational assessment completed at school or in the community?** ☐ YES ☐ NO

5. **Has your child had a formal hearing test?** ☐ YES ☐ NO

If yes, when was the test? _____

6. **Is your child receiving:**

Speech Therapy?	☐ YES	☐ NO
Occupational Therapy?	☐ YES	☐ NO
Physiotherapy?	☐ YES	☐ NO

Return this form Attention: _____

By mail to: **PARC**
3644 Slocan Street,
Vancouver, BCV5M 3E8
By fax to: **604-453-8390**