AUTISME ESTRIE

For Organization Use Only
Registration date : __/___ /_____
Administration signature : _____
Pages 1 to 12 completed : ☐

SERVICE REQUEST FORM

PARTICIPANT INFORMATION :

First Name : _____ Last Name: _____

Date of Birth (DD/MM/YYYY): _____ / _____ / _____

Address: _____

City: _____ Postal code: _____

Health Insurance Number: _____ Expiration date: _____

Diagnosis/Diagnoses: _____

PARENT/GUARDIAN CONTACT INFORMATION:

Name and Relationship to Participant: _____

(If different) Address: _____

City: _____ Postal code: _____

Telephone: _____ Mobile: _____

Email: _____

OTHER PARENT/GUARDIAN CONTACT INFORMATION (IF APPLICABLE):

Name and Relationship to Participant: _____

(If different) Address: _____

City: _____ Postal code: _____

Telephone: _____ Mobile: _____

Email: _____

AUTISME ESTRIE

LIST OF PROFESSIONALS INVOLVED IN THE PARTICIPANT'S CASE:

School or Day Program Attended: _____

Professional's Name: _____ CIUSSSE ☐ SCHOOL ☐ OTHER ☐

Position (Special Education Technician, Social Worker, etc.): _____

Phone : _____ Extension : _____

Email : _____

Professional's Name: _____ CIUSSSE ☐ SCHOOL ☐ OTHER ☐

Position (Special Education Technician, Social Worker, etc.): _____

Phone : _____ Extension : _____

Email : _____

HEALTH CONDITIONS:

Asthma : ☐ Hepatitis B : ☐ Diabetes : ☐ Epilepsy : ☐ Other(s) : ☐

Specify : _____

No known health conditions: ☐

ALLERGIES:

Medication(s) : ☐ Food : ☐ Insect stings : ☐ Other(s) : ☐

Specify : _____

No known allergies: ☐

SMOKING :

Does anyone smoke inside your home (cigarettes, cannabis, cigars, etc.)?

Yes : ☐ No : ☐

AUTISME ESTRIE

PETS:

Do you have any pets in your home? If yes, please specify the type of animal, the breed of the dog (if applicable), and the number of pets.

Yes : ☐ No : ☐

Specify : _____

_____

MÉDICAMENTS SOUS ORDONNANCE :

Medication Name	Condition Being Treated (ADHD, epilepsy, etc.)	Dosage	Time	Method of Administration
				With water: ☐ With puréed food : ☐ Other : ☐_____
				With water: ☐ With puréed food : ☐ Other : ☐_____
				With water: ☐ With puréed food : ☐ Other : ☐_____
				With water: ☐ With puréed food : ☐ Other : ☐_____

Pharmacy Name : _____

Phone : _____

AUTISME ESTRIE

OVER-THE-COUNTER MEDICATIONS THAT MAY BE ADMINISTERED:

Acetaminophen (e.g., Tylenol or Tempra) ☐

- *Dosage to be administered:* _____
- *Administration frequency:* _____
- *Conditions for administration (if applicable):* _____

Antiemetic (e.g., Gravol) ☐

- *Dosage to be administered:* _____
- *Administration frequency:* _____
- *Conditions for administration (if applicable):* _____

Antihistamine (e.g., Benadryl or Reactine) ☐

- *Dosage to be administered:* _____
- *Administration frequency:* _____
- *Conditions for administration (if applicable):* _____

Anti-inflammatory (e.g., Advil) ☐

- *Dosage to be administered:* _____
- *Administration frequency:* _____
- *Conditions for administration (if applicable):* _____

Cough syrup (e.g., Benylin) ☐

- *Dosage to be administered:* _____
- *Administration frequency:* _____
- *Conditions for administration (if applicable):* _____

Topical antibiotic (e.g., Polysporin) ☐

- *Dosage to be administered:* _____
- *Administration frequency:* _____
- *Conditions for administration (if applicable):* _____

Other: _____

- *Dosage to be administered: _____*
- *Administration frequency: _____*
- *Conditions for administration (if applicable): _____*

I authorize the in-home respite worker and Autisme Estrie to contact the pharmacy to exchange relevant information regarding medication, if necessary:

I agree ☐ I do not agree ☐

Parent/Guardian Name: _____

Signature: _____ Date (DD/MM/YYYY): _____

**I authorize the in-home respite worker to administer the prescription and over-the-counter medications listed above to my child, _____, as needed and in accordance with the specified administration times and dosages:*

I agree ☐ I do not agree ☐

Parent/Guardian Name: _____

Signature: _____ Date (DD/MM/YYYY): _____

COMMUNICATION :

Speaking (communicates using words) ☐ Limited verbal communication ☐ Non-speaking ☐

Engages in echolalia?	Yes ☐	No ☐
Understands and follows simple verbal instructions?	Yes ☐	No ☐
Is able to ask for help?	Yes ☐	No ☐
Communicates using gestures?	Yes ☐	No ☐
C Communicates using pictograms?	Yes ☐	No ☐
Uses a visual schedule at home or in another setting?	Yes ☐	No ☐

If yes, please describe the schedule used (e.g., pictograms, words, objects, size of pictograms, colour or black and white, vertical or horizontal layout, etc.):

_____

_____

Is the participant deaf or hard of hearing? Yes ☐ No ☐

Specify : _____

_____

Other specific characteristics: _____

_____

PERSONAL HYGIENE:

Wears a diaper or incontinence underwear?	Yes ☐	No ☐	
Uses the toilet:	Independently ☐	With assistance ☐	
Wipes themselves:	Independently ☐	With assistance ☐	
Washes hands:	Independently ☐	With assistance ☐	
Gets dressed / undressed:	Independently ☐	With assistance ☐	
Uses menstrual hygiene products?	Yes ☐	No ☐	Not applicable ☐
If applicable, changes their menstrual hygiene products:	Independently ☐	With assistance ☐	

Other specific characteristics: _____

_____

EATING HABITS:

Any specific eating habits or dietary preferences? Yes ☐ No ☐

Specify: _____

Any food intolerances? Yes ☐ No ☐

Specify: _____

What is the participant's appetite like? Low ☐ Moderate ☐ High ☐

Specify: _____

Eating pace: Fast ☐ Slow ☐

Tend to choke easily? Yes ☐ No ☐

Use the appropriate utensil for each type of food (spoon/fork)? Yes ☐ No ☐

Require assistance when using utensils? Yes ☐ No ☐

Does the food need to be cut ? Yes ☐ No ☐

Meal times at home: Breakfast : _____ Lunch : _____ Dinner : _____

Behaviours observed during meals (e.g., stays seated, eats standing up, screams, etc.):

_____

_____

Other specific characteristics: _____

_____

LIKES AND INTERESTS:

Favourite activities? (e.g., using a tablet, cooking, board games, colouring, etc.): _____

_____

Specific interests? (e.g., animals, colours, music, cars, etc.): _____

_____

AUTISME ESTRIE

FEARS OR PHOBIAS: Yes ☐ No ☐

Specify : _____

Intervention(s) to be implemented: _____

_____

SENSORY HYPERSENSITIVITIES OR SENSORY AVERSIONS: Yes ☐ No ☐

Specify : _____

Intervention(s) to be implemented: _____

_____

BEHAVIOURAL CHARACTERISTICS: Yes ☐ No ☐

Specify : _____

Intervention(s) to be implemented: _____

_____

TENDENCY TO WANDER OR RUN AWAY: Yes ☐ No ☐

Under what circumstances: _____

_____

Intervention(s) to be implemented: _____

_____

INGESTION OF NON-FOOD ITEMS (PICA): Yes ☐ No ☐

Under what circumstances: _____

_____

Intervention(s) to be implemented: _____

_____

AUTISME ESTRIE

SPECIFIC BEHAVIOURS:

Behaviours	Frequency	Under what circumstances?	Interventions to be implemented
Spitting	☐ Often ☐ Sometimes ☐ Never		
Pinching	☐ Often ☐ Sometimes ☐ Never		
Scratching	☐ Often ☐ Sometimes ☐ Never		
Screaming	☐ Often ☐ Sometimes ☐ Never		
Biting	☐ Often ☐ Sometimes ☐ Never		
Punching / Hitting	☐ Often ☐ Sometimes ☐ Never		
Kicking	☐ Often ☐ Sometimes ☐ Never		
Throwing or breaking objects	☐ Often ☐ Sometimes ☐ Never		
Inappropriate language (insults, swearing, etc.)	☐ Often ☐ Sometimes ☐ Never		
Tearing clothing	☐ Often ☐ Sometimes ☐ Never		

Self-injurious behaviour (biting, hitting, pinching oneself, etc.)	☐ Often ☐ Sometimes ☐ Never		
Sexual behaviours (masturbation, inappropriate touching, etc.)	☐ Often ☐ Sometimes ☐ Never		
Other Behaviours, Interventions, or Relevant Information			

AUTHORIZATION:

**I authorize the in-home respite worker and Autisme-Estrie to take photographs and videos of the participant during the provision of services, particularly for the creation of tools adapted to their needs:* I agree ☐ I do not agree ☐

Parent/Guardian Name: _____

Signature: _____ Date (DD/MM/YYYY): _____

** I authorize the in-home respite worker to provide the participant with appropriate first aid and emergency care, and to contact emergency services when necessary:*

I agree ☐ I do not agree ☐

Parent/Guardian Name: _____

Signature: _____ Date (DD/MM/YYYY): _____

**I authorize the in-home respite worker and Autisme-Estrie to communicate and receive, from the partners involved in the participant's case, the personal information necessary to ensure continuity and consistency in the services provided.*

The information exchanged may include, but is not limited to:

- *Interventions and support strategies;*
- *Behaviour prevention and management strategies;*
- *Diagnostic reports and information;*
- *Information regarding medication and the participant's medication profile;*
- *Recommendations and follow-ups from the professionals involved.*

The partners authorized to exchange information may include, for example, the CRDI, CIUSSS, physician, occupational therapist, healthcare professionals, school, special education technician (TES), etc. The information exchanged must be limited to what is necessary for the participant's follow-up and support. It may not be used for any purpose other than those specified in this authorization.

I agree ☐ I do not agree ☐

Parent/Guardian Name: _____

Signature: _____ Date (DD/MM/YYYY): _____

**By providing your personal information to complete these forms, you consent to your information being collected, retained, and used solely for the purpose of providing our services. Your information will be retained for as long as you use Autisme-Estrie's services. Your digital and paper files will be destroyed five years after the end of services.*
You also agree to keep confidential the names of individuals present during activities and any information or statements shared:

I agree ☐ I do not agree ☐

Parent/Guardian Name: _____

Signature: _____ Date (DD/MM/YYYY): _____

**These authorizations remain valid for the duration of the services provided by Autisme-Estrie. They may be withdrawn at any time by submitting a written request to Autisme-Estrie. Withdrawal does not affect the lawfulness of any information exchanges that took place before the withdrawal.*

AUTHORIZATION TO DISCLOSE INFORMATION CONTAINED IN THE FILE

AUTISME ESTRIE
2350, rue de Rouville - SHERBROOKE (QC) J1J1X8
Phone : (819) 822 - 3918
Fax : (819) 822 - 3127

First and Last Name (Participant/Service Recipient):	
Date of Birth: Year Month Day	
Current Address:	

I, the undersigned, _____
Last name , First name

Acting in my capacity as _____
E.g., service recipient, parent, legal guardian

I authorize: _____
E.g., name of the support worker and organization

To disclose to : _____
E.g.,Name of the support worker and organization

Regarding : _____

_____

This authorization is valid for the duration of the services provided, effective as of the date this document is signed. It may be revoked at any time upon request.

_____ Year Month Day
Signature: Participant/Service Recipient or Authorized Representative — Date

_____ Year Month Day
Witness to the Signature: — Date