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| **CENTRALIZED ACCESS DESK** **ID-ASD-PD DIRECTORATE****APPLICATION FOR SERVICES** |  |
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| **Identification of the client** |
| LAST NAME: |       | FIRST NAME: |       |
| Date of birth: |            | Gender: | F [ ]  M [ ]  |
| Health insurance number: |       | Expiry: |       |
| Address: |       | City:  |       | Postal code:        |
| Telephone: | Home:       | Cell:       | Work:       Ext.:       |
| Email: |       |
| Living environment: |       |
| Legal guardianship: | Mother [ ]  Father [ ]  Other [ ]  Specify:       |
| Father (name): |       | Tel.:       | Email:       |
| Mother (name): |       | Tel.:       | Email:       |
| Spouse: |       | Tel.:       | Email:       |
| Languages spoken: English [ ]  French [ ]  Other [ ]  Specify:       |
| Mode of communication: Telephone [ ]  TDD [ ]  | Legislation: AHSSS [ ] YPA [ ]  |
| **Applicant – Check if this is the same as the Identification of the client** [ ]  |
|  LAST NAME: |       | FIRST NAME: |       |
| Title or kinship: |       | Telephone: |       |
| Institution: |       | Program: |       |
| Address: |       |
| **Reason for the application** |
| Developmental delay: [ ] Disability related to: Motor development [ ]  Communication development [ ]  Cognitive development [ ]  Development of autonomy [ ]  | Intellectual disability [ ] Hearing impairment [ ] Language impairment [ ] Motor impairment [ ] Visual impairment – **complete Annex 1** [ ] Autism spectrum disorder [ ]  |
| Comments:       |
|  |
| **Medical and professional information** |
| Diagnosis or professional conclusion:       |
| Services in progress |       |
| Services received  |       |
| Treating physician |       | Telephone:  |       |
| **Professional or medical assessment relevant to the application** |
|  | Attached | To be sent |
| Medical report (neurology, physiatry, optometry, pediatrics, etc.) | [ ]  | [ ]  |
| Assessment in: speech therapy, occupational therapy, physiotherapy, audiology or ophthalmology | [ ]  | [ ]  |
| Psychological/neuropsychological or psychiatric/child psychiatric assessment | [ ]  | [ ]  |
| Other: (IP, IIP, court judgment, etc.)Specify:        | [ ]  | [ ]  |
| **Identification of risk factors** |
| [ ]  Health problem exacerbating the disability or the situation:        [ ]  Allergies:      [ ]  Behaviour that poses a risk to the client (recklessness, suicidal ideation, etc.):      [ ]  Human environment that poses a risk to the client’s safety (violence/neglect/isolation/absence or lack of support from loved ones, etc.):      [ ]  Physical environment that poses a risk to the client’s safety (clutter, not adapted, etc.):      [ ]  Exclusion from a living environment, currently or imminently (residence, school, leisure facility, childcare facility, etc.):      [ ]  Other:       |
| Comments:       |
| **Consent of the client or his/her legal representative**  |
| The client or his/her legal representative      : [ ]  Authorizes the professionals at the ID-ASD-PD Directorate to share or exchange information among themselves or with other directorates of the CISSS de Lanaudière in order to refer his/her application to the most appropriate services. [ ]  Authorizes the applicant (referrer) to provide the professionals at the ID-ASD-PD Directorate with the information and reports relevant to the client’s application for services. [ ]  Agrees to receive the services requested, including related disciplinary fields. |
| Name of applicant: |       | Signature: |       | Date:       |
| **Return the form to the ID-ASD-PD Centralized Access Desk**  |
| By mail: 1180, boulevard Manseau, Joliette (Québec), J6E 3G8By fax: 450-756-2898By email: guichet.ditsadp.cissslan@ssss.gouv.qc.caFor information: 1-877-322-2898 |