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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 3G8  By fax: 450-756-2898  By email: [guichet.ditsadp.cissslan@ssss.gouv.qc.ca](mailto:guichet.ditsadp.cissslan@ssss.gouv.qc.ca)  For information: 1-877-322-2898 | | | | | | | | | | | | | | | | | | | | | |