

# Diagnostic Form

## Autism Spectrum Disorder Individualized Funding

The personal information collected on this form will be used for the purposes of determining eligibility for Autism Spectrum Disorder Individualized Funding (ASD-IF) through the Ministry of Social Services and will be treated confidentially in compliance with the *Health Information Protection Act* and the *Freedom of Information and Protection of Privacy Act*. Any questions about the collection, use or disclosure of this information should be directed to the Ministry of Social Services, **1-833-304-1774 or autismif@gov.sk.ca**.

**This form is to be completed for:** Saskatchewan residents who have a child under the age of 12 who has received a diagnosis of Autism Spectrum Disorder (ASD) in order to access ASD-IF.

Child's Name:

Date of Birth:

Sask Health Services Number:

Parent/Guardian's Name:

### Section 1: Qualified Specialist Information

Name of Specialist completing the form:

**Discipline:**

Pediatrician

Physician (General Practitioner)

Registered Psychologist

Autism Spectrum

Disorder Consultant

Registered Social Worker

Psychiatrist

Nurse Practitioner

Work Address:

City/Town:

Postal Code:

Province/Territory:

Phone Number:

Fax Number:

Email Address:

College ID/Registration Number *(if applicable)*:

## Section 2: Autism Spectrum Disorder Diagnosis Information

(Please complete either 2a or b.)

### 2a. Confirmation of Diagnosis

(To be filled in by the qualified specialist\* who provided the ASD diagnosis.)

Please check box if the child has ASD  
according to criteria of DSM-5/ICD-10

Date of Diagnosis:

### 2b. Review of Existing Diagnosis

(To be filled in by qualified specialist\* reviewing and can confirm the ASD diagnosis.)

Please check box if you have reviewed the child's past assessments and can confirm the child has received  
a diagnosis of ASD according to the criteria of the DSM-5/ICD-10

Name of qualified specialist reviewing the diagnosis:

Location (City/Province/Territory):

Date of Diagnosis:

Name of qualified specialist who provided diagnosis:

Location (City/Province/Territory):

Date of Original Diagnosis:

Signature of Qualified Specialist Completing Form

Date Signed (mm/dd/yyyy)

## Section 3: To be filled out by Parent or Guardian

I consent to release this information to the Ministry of Social Services for the purpose of determining eligibility for Autism Spectrum Disorder Individualized Funding. This information will be treated confidentially and in compliance with the *Health Information Protection Act* and the *Freedom of Information and Protection of Privacy Act*.

Signature of Parent or Guardian Completing Form

Date Signed (mm/dd/yyyy)

**Please upload your completed diagnostic form to your application for individualized funding available at [autismfunding.saskatchewan.ca](http://autismfunding.saskatchewan.ca).**

If you are mailing in your application for individualized funding, please include this form.

*\*Pediatrician; Registered Psychologist; Physician (General Practitioner); Autism Spectrum Disorder Consultant; Registered Social Worker; Psychiatrist; Nurse Practitioner\**

If you have questions please contact your **ASD Consultant** or the **Ministry of Health** at [info@health.gov.sk.ca](mailto:info@health.gov.sk.ca) or **1-800- 667-7766**.