aspire

Special Needs Resource Centre

Welcome to the Aspire Family

You will now be receiving communications about family events, campaigns, groups and our e-newsletter.

If you do not wish to receive this information please let us know at any time by calling, emailing or by checking the box below.

☐ I do not wish to receive any communication from Aspire

Show your Support by Becoming a Member

Please check out the membership area of our website and sign up to become a member.

***If you are a service provider requesting services on behalf of a family please complete the back page.**

SERVICES APPLICATION

ASSESSMENT/CONSULTATION/THERAPY

If you are uncertain to the type of assessment/ consultation or therapy needed for your child please leave this form blank and the Intake Coordinator will contact you upon receipt of the application to discuss options for your child.

Requested Services

Team Assessment Services

☐TAC [illegible] ($1000)

__Partially funded__ 6 week diagnostic program with 3 therapists, behaviour specialist and special education teacher (scholarships are available for this service)

☐Diagnostic Clinic ($800)

__Partially funded__ two ½ day clinic -3 therapists (scholarships are available for this service)

☐Diagnostic Clinic ($2250)

Full fee two ½ day or one full day clinic-3 therapists (wait time tends to be shorter than the partially funded service)

☐Diagnostic Clinic ($1850)

Full fee two ½ day or one full day clinic-2 therapists (wait time tends to be shorter than the partially funded service)

☐FASD [illegible] ($5000)

Full fee two full day clinic-3 therapists

Area Specific Assessment Services

☐Psychological Assessment ($1400)

☐Physical Therapy Assessment ($600)

☐Occupational Therapy Assessment ($600)

☐Speech and Language Assessment ($600)

Consultation/Therapy

☐Psych ($140/hr.)

☐PT ($110/hr.)

☐OT ($110/hr.)

☐SLP ($110/hr.)

☐Behaviour Specialist ($110/hr.)

Please note that you may have health benefits that cover some or all of the costs of assessment and/or therapy. Please contact your benefit provider directly to see if you have coverage.

Your privacy is important to us:

Why we ask for parental relationship information and custody status?

In order to register a child in programming we require the legal guardian apply for services.

Child Information

Name:

First	Middle	Last

Date of Birth: ____ ____ ________ (MM DD YYYY) ☐ Male ☐ Female

Alberta Health Care # ______________________

Address ______________________

City: ______________ Province: ____ Postal Code: __________

Primary Care Giver Phone Numbers:

Home	Cell	Work

Parent/Guardian Information

Primary Contact

Name:

First	Middle	Last

Relationship to Child:

☐ Biological Mother ☐ Biological Father

☐ Step Mother ☐ Step Father

☐ Adoptive Mother ☐ Adoptive Father

☐ Foster Mother ☐ Foster Father

Phone Numbers:

Home	Cell	Work (Optional)

Email Address: ______________________

Place of Work: ______________ (Optional) Position: ______________ (Optional)

Your privacy is important to us:

Why we ask for employment information?

As a charitable organization we are on occasion able to receive funds from Workplace Donation Programs. If this is available through your workplace we will advise you of this possibility. Under no circumstances will we contact your employer without your consent.

Secondary Contact

Name:

First	Middle	Last

Relationship to Child:

☐ Biological Mother ☐ Biological Father

☐ Step Mother ☐ Step Father

☐ Adoptive Mother ☐ Adoptive Father

☐ Foster Mother ☐ Foster Father

Phone Numbers:

Home	Cell	Work (Optional)

Email Address: ______________________

Place of Work: ______________ (Optional) Position: ______________ (Optional)

It is important for us to know the status of the parental relationship in order to ensure we have consent for assessment from the custodial parent(s). Please state the status of your parental relationship below. ***Please provide a custody agreement if applicable.***

Parental Relationship and Custody Status:

☐ Married and living together (shared custody)

☐ Married and separated (If not shared custody a custody agreement is required)

☐ Not married and living together (shared custody)

☐ Not married and separated (If not shared custody a custody agreement required)

Are there any other persons living in the home with the child for whom you are applying for services for? If yes please provide names and relationship to child.

Application Information

What are your concerns?

Who have you spoken to about your concerns?

	Name	Phone Number
☐ Family Doctor:		
☐ Pediatrician:		
☐ Child Psychiatrist:		
☐ Behaviour Specialist:		
☐ Occupational Therapist:		
☐ Speech and Language		
☐ Physical Therapist:		
☐ Psychologist:		
☐ Other: ____________		

What concerns were identified by the above specialists? Please list these concerns below and identify which specialist shared these concerns with you.

Has your child ever been given a formal diagnosis?

☐ Yes ☐ No Comments?

Your privacy is important to us:

Why we ask about significant changes in your child's life?

A minimum of six months without any significant changes or major health concerns is required in order to ensure accuracy with our assessment services.

Is there a diagnosis/disability that you are concerned that your child might have?

☐ Yes ☐ No If yes, please explain:

At any time during your pregnancy did you consume alcohol or drugs?

☐ Yes ☐ No If yes, please explain:

Have there been any significant recent changes in your child's life (e.g. a new school, parental separation, etc.) or any significant illnesses (e.g. meningitis, seizures, slow weight gain)?

☐ Yes ☐ No If yes, please explain:

Infancy and Pregnancy

Please describe your pregnancy:

Did you take any medication/drugs during this pregnancy?

☐Yes ☐No If yes, please explain:

Did you use alcohol/drugs during your pregnancy?
☐ Yes ☐ No If yes, how frequently:

Child's birth weight: ____________________

During the birth did your child experience any difficulties (e.g. cord around the neck, breathing or injury)?
☐Yes ☐No If yes, please explain:

In the first few days following delivery, did your child have any problems? (e.g. sucking, rashes, breathing)
☐Yes ☐No If yes, please explain:

Health

Has your child's hearing been assessed recently?
☐ Yes ☐No If yes, what were the results?

Has your child's vision been assessed recently?
☐Yes ☐No If yes, what were the results:

Has your child been hospitalized or had surgery?
☐Yes ☐No If yes, please explain:

Has your child had visits to emergency departments?
☐Yes ☐No If yes, what for:

Does your child have any allergies?
☐Yes ☐ No If yes, what allergies?

Has your child used any medication for an extended period of time or are they using any medication currently?
☐Yes ☐ No If yes, what medication?

Does your child wet the bed or their pants?
☐ Yes ☐No

Does your child have accidents with bowel movements?
☐Yes ☐ No

Development

Indicate whether your child has met the following developmental milestones:

	Not able	Just beginning	Age Achieved
Sat up without help	☐	☐	________
Crawled	☐	☐	________
Walked alone (10+ steps)	☐	☐	________
Spoke first words (mama, dada, etc.)	☐	☐	________
Put words together	☐	☐	________
Spoke 2-3 word sentences	☐	☐	________
Spoke clearly (so strangers understood)	☐	☐	________
Fully bowel trained	☐	☐	________
Fully bladder trained	☐	☐	________
Separates easily from parent	☐	☐	________

Do you have any concerns about your child's speech and/or language?
☐Yes ☐No Please comment:

What is the principal language spoken at home?

Indicate others that are used sometimes:

Do you have any concerns about your child's fine motor skills (e.g. ability to use his/her hands to pick up objects, manipulate small objects, drawing, coloring, cutting, hand strength, etc.)?
☐ Yes ☐No   Please comment:

Do you have any concerns about your child's gross motor skills (e.g. rolling over, sitting, crawling, walking, running, jumping, hopping, balance, coordination and strength, etc.)?
☐ Yes ☐No   Please comment:

Do you have any concerns about your child's self-help skills (e.g. dressing, feeding, washing, toileting)?
☐Yes ☐No   Please comment:

Behaviour

Briefly describe your child's eating patterns, both past and current (e.g. poor appetite, unwillingness to try new foods, difficulty staying seated at the table, etc.):

Briefly describe your child's sleeping patterns, both past and current (e.g. falling asleep, sleeping through the night, where they sleep, length of sleep, etc.):

Describe this child's behaviour as an infant (e.g. happy, irritable, cried a lot, fussy, colic):

Please indicate below, whether the following behaviours apply to your child. If you answer yes, **please briefly describe the behaviour**.

	Yes	No
Has nervous habits (e.g. nail biting, thumb sucking)	☐	☐
Makes unusual noises or comments	☐	☐
Insists on sticking to unusual routines	☐	☐
Has difficulty with changes (e.g. in schedules)	☐	☐
Engages in repetitive behaviours	☐	☐
Engages in self-hurting behaviour (e.g. head banging)	☐	☐
Has frequent temper tantrums	☐	☐

	Yes	No
Is fearful	☐	☐
Talks back, argues	☐	☐
Has own agenda	☐	☐
Has trouble making new friends/keeping friends	☐	☐
Has difficulty waiting turn	☐	☐
Has extreme reaction to noises, smells or touch	☐	☐
Resistant to change	☐	☐
Impatient, easily frustrated	☐	☐
Has mood swings, over-reacts	☐	☐

	Yes	No
Refuses to do things	☐	☐
Gets into fights	☐	☐
Has difficulty sustaining attention	☐	☐
Does not seem to listen or follow directions	☐	☐
Difficulty organizing tasks and activities	☐	☐
Forgetful in daily activities, needs reminders	☐	☐
Fidgets with hands or feet or squirms in seat	☐	☐
Runs or climbs excessively when it is inappropriate	☐	☐
Difficulty playing quietly	☐	☐

	Yes	No
“On the go”, acts as if driven by a motor	☐	☐
Talks excessively	☐	☐
Interrupts or intrudes on others’ speech	☐	☐
Impulsive (e.g. acts without thinking)	☐	☐
Daydreams	☐	☐

Describe how you typically address any behavioural concerns your child may have:

Interactions/Relationships

Describe, in general, how you and your child get along with each other each day:

Describe how your child gets along with other family members:

Describe how your child gets along with peers (e.g. in play):

Is there anything else you feel that we should know about your child and family?

Additional Comments:

Have you or your family been involved with Aspire Special Needs Resource Centre in the past?

☐ Yes ☐ No If yes, how so?

Who referred you to Aspire Special Needs Resource Centre? Please provide name and relationship (Friend, Speech and Language Pathologist, Doctor etc…).

____

I hereby certify that the information provided on this form is true, correct and complete to the best of my knowledge and I will keep Aspire Special Needs Resource Centre advised of any changes.

Parent/Guardian Name	Parent/Guardian Name	Date

TO COMPLETE YOUR APPLICATION PLEASE SUBMIT THE FOLLOWING:

- This application form
- Application Fee: $50.00
  We accept cash, cheque, debit, and credit card (credit card can be accepted over the phone).
- All reports and assessments that have been completed on your child.
- If applicable, please attach a custody agreement.

Thank you for applying.
You will be notified and added to our wait list as soon as your application and payment is received.

Complete this page if you are requesting services on behalf of a family.

Person Requesting Services:

Name	Title

School Agency: ______________________________

Address: ______________________________

City: ______________ Province: ______ Postal Code: ______________

Phone Number: ______________________________

Email Address: ______________________________

Address of Service: ______________________________

Additional Information: