aspire
Special Needs Resource Centre

SERVICES APPLICATION

Please check the box of the service you are applying for.

If you are uncertain to the type of service needed for your child, please leave this page blank and the Intake Coordinator will contact you upon receipt of the application to discuss options for your child.

Team Assessments:

☐TAC-Transdisciplinary Assessment and Consultation ($1000)
Partially funded 6 week diagnostic program with 3 therapists, behaviour support and special education teacher (fee assistance is available for this service)

☐Diagnostic Clinic ($800)
Partially funded two ½ day clinic-3 therapists (fee assistance is available for this service)

☐Diagnostic Clinic ($2400)
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 ($2000)
Full fee two ½ day or one full day clinic-2 therapists (wait time tends to be shorter than the partially funded service)

Individual Assessment Services:

☐Psychological Assessment ($1550)
☐Physical Therapy Assessment ($600)
☐Occupational Therapy Assessment ($600)
☐Speech Language Assessment ($600)

Consultation/Therapy Services:

☐Psychologist ($140/hr.)
☐Physical Therapist ($110/hr.)
☐Occupational Therapist ($110/hr.)
☐Speech Language Pathologist ($110/hr.)
☐Behaviour Specialist ($110/hr.)

Preschool Services

☐EASE (Early Access to Supportive Education) ($150/month)
Partially funded by Program Unit Funding (PUF) Fee assistance is available for this service.

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.

Family Information

Child's Full Name: ____

Date of Birth: ______________________________ ☐ Male ☐ Female

Alberta Health Care # ____

Child's Address: ____

City: ______________________ Province: __________ Postal Code: ____________

Parent/Guardian (primary contact): ______________________________________

Relationship to Child:

☐Biological Mother ☐Adoptive Mother ☐Step Father ☐Grandfather
☐Step Mother ☐Biological Father ☐Adoptive Father ☐Grandmother
☐Foster Mother ☐Foster Father

Address (if different from child): ______________________________________

City: ______________________ Province: __________ Postal Code: ____________

Home Phone Number: ______________________Cell: ______________________

Email Address: ______________________________Place of Work: ______________________
(Optional)

Parent/Guardian (secondary contact): ______________________________________

Relationship to Child:

☐Biological Mother ☐Adoptive Mother ☐Step Father ☐Grandfather
☐Step Mother ☐Biological Father ☐Adoptive Father ☐Grandmother
☐Foster Mother ☐Foster Father

Address (if different from child): ______________________________________

City: ______________________ Province: __________ Postal Code: ____________

Home Phone Number: ______________________Cell: ______________________

Email Address: ______________________________Place of Work: ______________________
(Optional)

Parental Relationship and Custody Status:

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.

☐ Single ☐ Married/living together ☐ Separated/ Divorced ☐ Widowed

☐ Sole custody (please provide a copy of the custody agreement)
☐ Joint/Shared custody (please note that both parents will be required to consent to services if not living at the same address as the child)
☐ Retained custody (in the case of the death or desertion of one parent)
☐ Alternating/Divided custody (please provide a copy of the custody agreement)
☐ Third party custody (please provide a copy of the custody agreement)

Others living in the Home with the Child:

Name	Relationship	Age (if child)

School Information (complete if applicable)

School your child currently attends: ____

Grade: ____________

Teacher: ________________________________ Education Assistant (EA): ____________________

School your child will attend next school year if known: ______________________________________

Community Services

Please provide the names, addresses and telephone numbers of those persons with whom you have been involved with on behalf of your child. (*Please take the time to complete in full*)

	Name	Clinic/Address	Phone	Involvement
FAMILY DOCTOR				☐ Past ☐ Current
PEDIATRICIAN				☐ Past ☐ Current
PSYCHOLOGIST				☐ Past ☐ Current
OCCUPATIONAL THERAPIST				☐ Past ☐ Current
SPEECH LANGUAGE PATHOLOGIST				☐ Past ☐ Current
PHYSICAL THERAPIST				☐ Past ☐ Current
AUDIOLOGIST				☐ Past ☐ Current
NEUROLOGIST				☐ Past ☐ Current
PSYCHIATRIST				☐ Past ☐ Current
FSCD (FAMILY SUPOORTS FOR CHILDREN WITH DISABILITIES)				☐ Past ☐ Current
CHILD DEVELOPMENT CONSULTANT/ BEHAVIOUR SPECIALIST				☐ Past ☐ Current
EARLY INTERVENTION STAFF (AHS)				☐ Past ☐ Current
OTHER				☐ Past ☐ Current

Concerns

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

☐ Yes ☐ No If yes, please explain:

Please tell us what concerns you have for your child that has brought you to apply for services? (Please be specific)

Who have you spoken to about your concerns? (Ex.Pediatrician, Family Doctor, Speech Language Pathologist, Early Intervention Staff, School)

Did the professionals share your concerns or identify concerns? ☐ Yes ☐ No

Please explain:

Has your child ever been given a formal diagnosis? ☐ Yes ☐ No

If **yes**, please share the diagnosis and if there is an additional diagnosis you are wondering about.

If **no**, is there a diagnosis you are concerned your child might have?

Family Medical History

Has anyone in your family been diagnosed with a developmental (Autism, ADHD, etc.) or mental health condition (Depression, Anxiety, etc.)? ☐Yes ☐No

If yes, please explain:

Has anyone in your family been diagnosed with learning and or reading concerns? ☐Yes ☐No

If yes, please explain:

Pregnancy and Infancy

Child's birth weight: ______________________

Mother's age at time of conception: ___________________

Father's age at time of conception: ___________________

Were there any difficulties during the pregnancy or birth (e.g. extreme morning sickness, gestational diabetes, cord around the neck, breathing or injury)?

☐Yes ☐No If yes, please explain:

In the first few days following delivery, did the child have any problems? (e.g., feeding, rashes, breathing)

☐Yes ☐No If yes, please explain:

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

Were medications taken during this pregnancy?

☐Yes ☐No If yes, please explain:

Were alcohol/drugs taken during this pregnancy?

☐ Yes ☐ No If yes, how frequently:

Health

Please note that it is recommended that all children have their hearing and vision tested prior to your assessment date at Aspire.

Has your child's hearing been assessed? ☐ 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?

Development

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

If yes, please explain:

Please provide the age your child achieved the following:

1. Spoke first words
   (Mama, dada, etc.)

2. Put words together
   (Spoke 2-3 word sentences)

3. Spoke clearly
   (So strangers understood)

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, colouring, 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:

Please provide the age your child achieved the following:

1. Sat up without help
2. Crawled
3. Walked alone (10+ steps)

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

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

If no, at what age were they fully bladder trained?

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

If no, at what age were they fully bowel trained?

Eating Patterns

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.):

Sleeping Patterns

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, use of sleep aides like melatonin, etc.):

Behaviours

Please indicate below, whether the following behaviours apply to your child.

- ☐ Nail biting or 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-harming behaviour (e.g., head banging)
- ☐ Has frequent temper tantrums
- ☐ Is fearful
- ☐ Talks back, argues
- ☐ Has own agenda
- ☐ Has trouble making new friends/keeping friends

- ☐ Has difficulty waiting their turn
- ☐ Has extreme reaction to noises, smells or touch
- ☐ Resistant to change
- ☐ Impatient, easily frustrated
- ☐ Has mood swings, over-reacts
- ☐ 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
- ☐ "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 how your child separates from you? (easily or with difficulty) Please describe.

Describe, in general, how you and your child get along with each other on a daily basis:

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?

Referent:

Name: ______________________________________ Title: _____________________________

School/Agency/Clinic: ____

If not referred, how did you hear about Aspire?

- ☐ Involved with Aspire in the past
- ☐ Website
- ☐ Other ___________________________
- ☐ Social media
- ☐ Newspaper/magazine

Please Sign Here

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 of $50.00 (cash, cheque, debit, credit card)
- All reports and assessments that have been completed with your child
- Copy of the custody agreement (if applicable)
- Copy of birth certificate or passport if applying for the preschool program (EASE)

As part of the Aspire family you will now be receiving communication from Aspire through email about family events and our e-newsletter.

If you do not want to receive emails, please indicate that by checking the box. ☐ *No emails please*

Person requesting services (if not the parent)

Name and Title: ____

School /Agency: ____

Phone Numbers: ____

Email Address: ____

Payment of fees: ____

Who can I contact if I have questions or concerns regarding my Privacy?

JoAnne Hayden, Privacy Officer jhayden@aspirespecialneeds.ca 403 340-2606 ext. 219