

Aspire Child Development Centre

Assessment Consultation and Training Services

Application Form



Family Information

Child's Full Name

First: _____ Middle: _____

Last: _____

Birth Date (Month/Day/Year): _____

Male Female Other _____

Alberta Health Care Number: _____

Child's Home Address:

Address: _____

City: _____ Province: _____ Postal Code: _____

Parent/Guardian (primary contact):

Name: _____

Relationship to Child:

Mother Stepmother Foster Mother Adoptive Mother

Father Stepfather Foster Father Adoptive Father

Paternal Grandfather Maternal Grandfather

Paternal Grandmother Maternal Grandmother

Contact Phone Number: _____

Address (if different from child): _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

Parent/Guardian (secondary contact):

Name: _____

Relationship to Child:

Mother Stepmother Foster Mother Adoptive Mother

Father Stepfather Foster Father Adoptive Father

Paternal Grandfather Maternal Grandfather

Paternal Grandmother Maternal Grandmother

Contact Phone Number: _____

Address (if different from child): _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

Others Living in the Child's Home

Name: _____

Relationship: _____ Age (if child): _____

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 copy of 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 death or desertion of one parent)

Alternating/Divided custody (please provide copy of custody agreement)

Third party custody (please provide copy of custody agreement)

School/Daycare Information (complete if applicable):

School your child currently attends: _____ Grade: _____

Teacher: _____ Email Address: _____

Education Assistant (EA): _____ Email Address: _____

School Contact for Services: _____ Title: _____

Email Address: _____ Phone Number: _____

Do you currently have a physician? Yes No

Community Services

Please take the time to complete in full.

Service/Professional	Name	Clinic/Address	Phone	Involvement
Family Doctor				<input type="checkbox"/> Past <input type="checkbox"/> Current
Pediatrician				<input type="checkbox"/> Past <input type="checkbox"/> Current
Psychologist				<input type="checkbox"/> Past <input type="checkbox"/> Current
Occupational Therapist				<input type="checkbox"/> Past <input type="checkbox"/> Current
Speech Language Pathologist				<input type="checkbox"/> Past <input type="checkbox"/> Current
Physical Therapist				<input type="checkbox"/> Past <input type="checkbox"/> Current
Audiologist				<input type="checkbox"/> Past <input type="checkbox"/> Current
Neurologist				<input type="checkbox"/> Past <input type="checkbox"/> Current
Psychiatrist				<input type="checkbox"/> Past <input type="checkbox"/> Current
FSCD (Family Supports for Children with Disabilities)				<input type="checkbox"/> Past <input type="checkbox"/> Current
Child Development Consultant/ Behaviour Specialist				<input type="checkbox"/> Past <input type="checkbox"/> Current
Early Intervention Staff (AHS)				<input type="checkbox"/> Past <input type="checkbox"/> Current

Other				<input type="checkbox"/> Past <input type="checkbox"/> Current
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Concerns

I have concerns for my child in these area(s) - (check all that apply):

Psychology

Academic Learning

- | | |
|---|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Reading comprehension (understanding what they read) |
| <input type="checkbox"/> Mathematics | <input type="checkbox"/> Child's work is being modified |
| <input type="checkbox"/> Performing below grade level expectations | <input type="checkbox"/> Written compositions |
| <input type="checkbox"/> Child is receiving small group or individual interventions | |

Behaviour

- | | |
|--|--|
| <input type="checkbox"/> Depressive symptoms (low motivation, not completing or handling in homework, low academic achievement, excessive missing of school days, withdrawn) | <input type="checkbox"/> Anxious presentation (activity or school avoidance or refusal, excessive complaints of physical symptoms of illness without underlying medical cause, excessive reports of worries) |
| <input type="checkbox"/> Aggression (hitting, pushing, kicking, pinching, scratching, biting, throwing things) | <input type="checkbox"/> High need for physical movement |
| <input type="checkbox"/> Inflexibility (difficulty adapting to change) | <input type="checkbox"/> Noncompliance with following adult directions or instructions |
| <input type="checkbox"/> Unsafe behaviour (bolting, unsafe climbing, etc.) | <input type="checkbox"/> Inattention, difficulty with focus and concentration |
| <input type="checkbox"/> Hyperactivity | |

Emotional Regulation

- Ability to calm oneself and control anger.

Social Skills

- | | |
|---|---|
| <input type="checkbox"/> Initiating and maintain social relationships with peers | <input type="checkbox"/> Respecting the personal boundaries of others |
| <input type="checkbox"/> Displaying appropriate social behaviours (manners, appropriate topics of conversation) | |

Physical Therapy

- | | |
|---|---|
| <input type="checkbox"/> Equipment needs (wheelchair, brace, walker, or standing frame) | <input type="checkbox"/> Lifts and transfers (does your child require assistance moving from one location to another) |
|---|---|

- Posture and positioning (lying, sitting, standing)
- Stairs
- Participation on playground or gym activities
- Gross motor activities (running, jumping, throwing, catching)
- Body awareness or motor planning

- Mobility or gait
- Frequent falls
- Balance and coordination
- Quality of movement (awkward, stiff, floppy)

Occupational Therapy

Fine Motor

- Grasp on tools (pencil, scissors)
- Cutting
- Drawing/printing
- Using hands functionally

Sensory Regulation

- Over responsive to sensory input (visual, auditory, tactile, movement)
- Under responsive to sensory input (visual, auditory, tactile, movement)
- Interoception (understanding body cues, e.g. Hunger, pain)
- Body awareness and motor planning

Self Help

- Toileting
- Feeding
- Dressing
- Independence

Speech-Language Pathologist

Speech (articulation/speech sounds)

- Difficult to understand
- Speech difficulty limits peer interaction or participation

Language

- Difficulty following directions or answering questions
- Difficulty remembering long pieces of verbal information
- Uses many "empty words" (e.g. stuff, thing)
- Participation in discussions
- Talks around a word/uses a description instead of the word ("temperature thing" for thermometer) or substitutes the name of a related item (e.g. "knife" for "scissors" etc.)
- Produces grammar errors (pronoun errors "her is going" etc.)

Social skills (social communication and interactions with others)

- Provides off topic answers, comments, or actions
- Difficulty making friends

Stuttering

Repeats sounds, syllables, words or phrases

Voice

Clears their throat or coughs more than others

Voice is husky, hoarse or gravelly

Please expand on any concerns you have for your child that has brought you to apply for services.

Diagnostic Information

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 wondering about or that has been queried?

Based on the concerns you have described above, which services are you applying for?

<input type="checkbox"/> Diagnostic Clinic	<p>A diagnostic team works together to assess areas of concern. An assessment report along with recommended strategies is provided. Diagnostic teams consist of a psychologist and speech language pathologist and/or an occupational therapist, depending on identified concerns.</p> <p>Diagnostic Clinics are booked as one full day or two ½ days.</p> <p>Fees range from \$1,300 to \$2,800.</p> <p>Children and teens up to 17 years, 11 months are eligible for Diagnostic Clinics.</p> <p>Please check your benefits - Direct billing is available for some service providers.</p>
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<input type="checkbox"/> Therapist Specific Assessments	Not currently available.
<input type="checkbox"/> Transdisciplinary Assessment and Consultation Program 6-week parent program	<p>Over six weeks, you will work with a transdisciplinary team who will get to know both you and your child. Once we understand what you are going through, we will offer strategies to support both your child and your family. At the end of the program, you will receive a transdisciplinary diagnostic report.</p> <p>Assessment program runs over 6 weeks and includes 5 weeks of programming, Monday to Thursday mornings and a case conference (wrap up meeting) in the 6th week.</p> <p>Fee is \$1,500. Children up to 7 years, 11 months are eligible for the TAC Program. Please check your benefits - Direct billing is available for some service providers.</p>

Our Aspire team will contact you once your application is received and will talk through the services ensuring you have applied for the service that best meets your needs.

Does your child have Health Benefit Coverage? Yes No

If yes, please include information.

Primary:

Plan Holder: _____ Plan Holder DOB: _____

Insurance Company Name: _____ Plan/Certificate/Group Number: _____

ID Number: _____ Child's Name: _____

Child's ID (if different form above): _____

Secondary:

Plan Holder: _____ Plan Holder DOB: _____

Insurance Company Name: _____ Plan/Certificate/Group Number: _____

ID Number: _____ Child's Name: _____

Child's ID (if different form above): _____

Fee Assistance:

Fee Assistance applications are available for those requiring financial support and are currently facing financial challenges in accessing Aspire Services.

Would you like more information regarding Fee Assistance? Yes No

Interpretation Services:

Would you like to discuss interpretation services for your appointment?

We may be able to provide a professional interpreter through tele-interpretation services at no cost to you for certain portions of your appointment, depending on availability and need.

Yes, I would like to discuss interpretation services.

Preferred language: _____

No, I do not need interpretation services at this time.

Referent:

Name: _____ Title: _____

School/Agency/Clinic: _____

If not referred, how did you hear about Aspire?

Involved with Aspire in past Website Newspaper/magazine Social Media

Other _____

Person requesting services (if not the parent):

Name: _____

Title: _____

School/Agency: _____

Email Address: _____

Phone Number: _____

Payment of Fees: _____

To complete your application,
please submit the following:

- This application form
- All reports and assessments that have been completed with your child.
- Copy of your FSCD contract
- Copy of the current custody agreement (if applicable)

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

Aspire Child Development Centre complies with all relevant privacy legislation. All information collected will be compiled for the exclusive use of Aspire Child Development Centre and will not be available for any other organization.

Guardian - 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 Child Development Centre advised of any changes.

Parent/Guardian Name (Print Name)

Parent/Guardian (Signature)

Parent/Guardian Name (Print Name)

Parent/Guardian (Signature)

Date

If you have any questions or concerns regarding privacy, you may contact Jordan MacDonald, Privacy Officer at: jmacdonald@aspirechild.ca or 403-340-2606.