# APPENDIX A – Confirmation of Diagnosis Form

**CHILD'S INFORMATION** (To be completed by professional)

Name:_____ Gender:_____

Family Physician:_____ Birth Date:_____
(mm/dd/yyyy)

Diagnosis: ☐ Autism Spectrum Disorder (ASD) Language of Service ☐ French ☐ English

Diagnostic Assessment Tools used: _____

_____

**DIAGNOSING PROFESSIONAL'S INFORMATION** (To be completed by Pediatrician, Physician, Psychologist, Pediatric Neurologist or Psychiatrist)

Profession: ☐ Physician: _____
(Speciality)
☐ Psychologist
☐ Other:_____

Name:_____

Address:_____
(suite, number, building, street)

_____
(city/town/village) (province) (postal code)

Telephone #:_____ Signature:_____ _____
(mm/dd/yyyy)

**APPLICATION FOR SERVICES** (To be completed by parent(s)/guardian)

Parent/Guardian's Name:_____

Mailing address:_____
(apt., number, street)

_____
(city/town/village)

_____ _____ _____
(province) (postal code) (telephone #)

_____
(email address)

_____
Guardian's Signature

Parent/Guardian's Name:_____

Mailing address:_____
(apt., number, street)

_____
(city/town/village)

_____ _____ _____
(province) (postal code) (telephone #)

_____
(email address)

_____
Guardian's Signature

**Parental or guardian signature indicates agreement with the information provided and gives consent to be contacted by Education and Early Childhood Development regarding services and gives permission for the diagnosing professional to send the Confirmation of Diagnosis and diagnostic write-up to the Preschool Autism Program of EECD.**

**Please mail the completed form to:**
Autism/Autisme - Education and Early Childhood Development - P.O. Box 6000 - Place 2000 - 250 King Street - Fredericton, NB E3B 9M9
**This form is also available for print on the GNB website at:**
**http://www2.gnb.ca/content/gnb/en/services/services_renderer.13836.Services_for_Preschool_Children_with_Autism_Spectrum_Disorders.html**