Children's Treatment Network

SIMCOE-YORK ABA - REPEAT SERVICE INTAKE FORM

CTN Client Record #_____ **Round #** -_____

CHILD/YOUTH INFORMATION			
First Name:		**Birthdate:** (dd/mmm/yyyy)	
Surname:		☐ M ☐ F	
Street Address:		**Apt/Unit/Suite #**	
City/Town:		**Postal Code:**	

☐ I provide consent for the collection and sharing of information between Children's Treatment Network, Kinark Child and Family Services, Kerry's Place Autism Services and Centre for Behaviour Health Sciences for the purpose of the ABA Program and any other services or supports involved with my child.

Family Email: _____

_____
Parent Signature OR Verbal Consent Obtained By

CONTACT INFORMATION FOR PARENT(S)/GUARDIAN OF CHILD/YOUTH			
PRIMARY CONTACT		**SECONDARY CONTACT**	
Full Name:		**Full Name:**	
Relationship:	-	**Relationship:**	-
Full Address:	☐ same as child/youth OR	**Full Address:**	☐ same as child/youth OR
Home Phone:		**Home Phone:**	
Cell Phone:		**Cell Phone:**	

☐ **CUSTODY:** -_____ ☐ **INTERPRETER REQUIRED FOR LANGUAGE:** _____

FOR COMPLETION BY ABA CONSULTANT			
Name:		**Agency:**	--

Consultant identifies that family needs assistance with: _____

Rationale for this referral to CTN Service Navigation (please use the space below):

Discharge Date:

FOR COMPLETION BY CHILDREN'S TREATMENT NETWORK – INTAKE STAFF ONLY			
New Eligibility Date:		**Time:**	
☐ **Eligibility Confirmed by:**	**(CTN Access Intake Staff)**	**1-866-377-0286, Ext. 4201**	

Mail To: Children's Treatment Network, #501-80 Bradford Street, Barrie, ON L4N-6S7 or Fax To: (705) 792-2775

Revised: September 1, 2015