**Call Received by Non Gateway Agency: *If your organization does not currently provide ongoing service navigation for people with ASD and their families please use the following process to determine the correct linkages***

* Inquiry received regarding ASD services and supports
* Intake Point determines where to direct client/family based on:

 - Does the Child/Youth have an ASD diagnosis?

 - Age?

 - Is any agency already providing Services?

* If able, check to see if there is a shared electronic record open, document the call in the record and load documents, diagnosis, custody paper, reports etc if obtained using YYYY/MM/DD, name of document, initials of individual..
* If no record is open, or unable to access record, complete YORK ASD Partnership Transfer Form (**Form Attached**)
* Initiate Warm Transfer Protocol\* to appropriate Gateway Agency (**Warm Transfer Protocol**)
* Follow up with Gateway Agency:
	+ Calling the Gateway agency, and making a live transfer directly to the Gateway agency
	+ By emailing the shared record number indicating Warm Transfer or
	+ Forwarding (FAX, Courier) the YORK ASD Partnership Transfer Form to the Gateway agency
* Document Consent to transfer in Agency Documentation system (Retain copy of the Transfer form)

**Call/Transfer Received by Gateway Agency**

* Inquiry received regarding ASD services and supports
* Gateway Agency checks Network’s Shared Electronic Record to see if client already has a record opened and whether services and supports have already been initiated:
	+ If client’s record exists, Gateway agency uses the shared record to document, and updates demographic and consent screens using script provided.
	+ If no client record exists, Gateway agency opens a Shared Electronic Record, completing Demographic, Diagnostic, Contact and Consent Screens at a minimum (See attached, **Opening A Shared Record**)

* Gateway agency:
	+ Continues with client/family to confirm information, discuss needs and current supports and services and next steps
	+ Initiates assessment and initial service planning per its mandate
* Forwards referrals to appropriate partners and documents information in Shared Record ; For referrals to agencies using the Network’s Shared Record – Agencies will use Client’s Shared Record Number to communicate with agencies who have access to the Shared Record in order to minimize faxing, copying and sending of client information

**Date of Inquiry:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Child/Youth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Call:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does Child/Youth have an ASD Diagnosis? □Yes □ No**

If yes, please indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(YYYY/MM/DD)

**Does Child/Youth have a Shared Record Opened? □Yes □ No □Don’t Know**

If yes, Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child/Youth’s Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Person Calling:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Person with ASD □Mother □Father □Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Custody** \_\_ BothParents \_\_ Joint Custody \_\_Sole Custody \_\_Mother \_\_ Father \_\_other

**First Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter required \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Caller’s Address**: □same as Child/Youth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Numbers:**

**Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Best Day to Call** □M □T □W □Th □ F

**Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Best Number to Call** □Home □Cell □Work

**Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(To be used only for the purposes of contact and sharing of general information. No client information will be shared by email)*

□Client/Parent agrees to the sharing of this information with York ASD Partnership agencies for the purposes of referral and initial service planning**. Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**­­­­­­­­­­­­­­­­­­­­­­­­­**

**Completed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Agency**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E MAIL Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gateway Agency Receives ASD Partnership Transfer Form or Call from Client/Family**

**PROCESS for Opening A Shared Electronic Record**

* Check to see if Shared Record already Exists by entering first three letters of client’s first and last name/first last name reversal and last name only –if yes, ensure information is current and accurate, update demographic, diagnostic and contact information
* Confirm Contact Information: add relevant family and provider information
* Enter/Confirm **Diagnosis** in Diagnostic Field – can add multiple Diagnosis –Diagnosis must be a valid Diagnosis
* Update **Complete Consent to Share Information** screen
* Upload relevant Reports Documents in **Document Manager** including Transfer Form
* Schedule next step in Process -?Further Assessment and Network Consent to Share Information *(this may or may not occur at the time of this initial contact – if yes continue with Assessment and consent activities and referral out)*
* Document in **Notes:** contact with client/family, appointments if appropriate, the referrals that have been made, next steps.

**If Shared Record does not exist:**

* Switch to Full Client GoldCare Application – this application is required to open a new client file
* Complete **Demographic information** fields under Intake Tab – ensure that all mandatory fields are completed
* Enter **Contact Information** for Parent/Guardian, add relevant family and provider information
* Enter appropriate **Program and Stage** for Service –

 EIS York Region = 0-6yrs Program Stage= Waiting Assessment

 CTN = Referral Program = Referral Received

 KPAS= Autism Services Program= Waiting Assessment

Include date of Program Admission, Agency Providing Service and Name of Service Provider

* Enter **Diagnosis** in Diagnostic Field – can add multiple Diagnosis –Diagnosis must be a valid Diagnosis
* Upload relevant Reports Documents in **Document Manager** including Transfer Form
* Schedule next step in Process -? Further Assessment and Network Consent to Share Information *(this may or may not occur at the time of this initial contact – if yes continue with Assessment and consent activities and referral out)*
* If Appropriate at this time **Complete Consent to Share Information** screen *(depends on status of assessment and referral out process)*
* Document in **Notes:** contact with client/family, appointments if appropriate, the referrals that have been made, next steps.