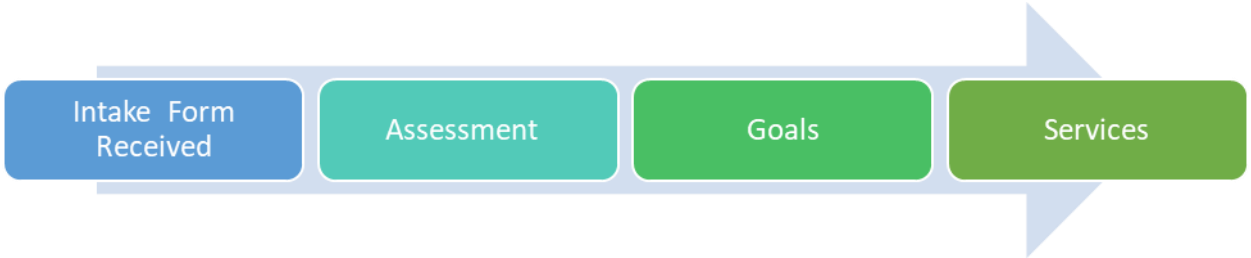
11 Nadolny Sachs Private, Suite #218
Ottawa, ON
K2A 1R9
(613)-725-3519
consultations@tamir.ca

NEW!!! Professional Consultation Services

We are so excited to announce that Tamir will be offering remote Professional Consultation Services to help improve the quality of life of your child and family. Tamir has been generously given a grant by the M.B. Lewis Charitable Foundation that will help fund this new project. Please note that if you have insurance, this may potentially be applied to this service and may increase the number of sessions possible.

Tamir is offering professional services in a 5-session remote consultation model. To access the professional services, the first step is to complete the intake/consultation form. Once completed, you will be contacted within 48 hours. The need for professional services will be discussed and a possible intake through Zoom will be conducted. There will be 5 consultation sessions that will be arranged with the appropriate professional through tele-health where a treatment plan and follow-up will be discussed. In order to assess the impact of this new service on the community and clientele, a parental satisfaction survey will be provided for families to complete after each consultation.

If you have any questions, please do not hesitate to contact us at consultations@tamir.ca



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APPLICATION FORM

REMOTE PROFESSIONAL CONSULTATION

PERSONAL INFORMATION

CLIENT'S INFORMATION		
Child's Last Name:	Child's First Name:	
Date of Birth:	Age:	Gender: M ☐ F ☐
Place of Birth:	Religion:	
Languages Spoken at Home:		
Name of School/Daycare:		
Legal Guardian(s): (Please indicate the legal guardian for the client with an X on the appropriate block): ☐ Father & Mother ☐ Father ☐ Mother ☐ Other (Indicate Relationship):_____		
Lives with: ☐ Father & Mother ☐ Father only ☐ Mother only ☐ Other (Indicate Relationship):_____		

List Siblings (Living at Home)	Gender	Date of Birth	School/Grade

PARENTS/CAREGIVERS		
Mother's Name (First/Last):		
Address		Email Address
Home Phone:	Cell Phone:	Work Phone:

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Father's Name (First/Last):		
Address		Email Address
Home Phone:	Cell Phone:	Work Phone:
Caregiver's Name (First/Last) (if applicable):		
Address		Email Address:
Home Phone:	Cell Phone:	Work Phone:
Emergency Contact Name(not parent):	Emergency Contact Phone:	Emergency Contact Relationship:

GENERAL INFORMATION

CLIENT'S INFORMATION	
Does your child have a diagnosis?	Diagnosis (if yes):
What are your areas of primary concern? 1. 2. 3.	
What objectives do you want your child to work on?	
What professional service do you feel you will require to support these objectives (i.e. behavior analyst, psychologist, speech language pathologist, occupational therapist, social worker, etc..).	

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What services is your child currently receiving (check all that apply)		
□ Speech and Language Pathology (SLP)	□ Applied Behavior Analysis Therapy (ABA)	□ Art Therapy
□ Occupational Therapy (OT)	□ Physiotherapy	□ Music Therapy
Other (please describe):		

CHILD'S PROFILE

Describe your child in your own words.

What does your child enjoy doing? What are your child's likes/interests?

What does your child not enjoy?

What are some reward and/or reinforcers that your child enjoys (i.e. stickers, hi5, hugs, walks, books etc..)

In your opinion, what are your child's greatest strengths?

In your opinion, what are your child's greatest needs (areas of improvement/challenges)?

Is there anything else you would like to tell us about your child?

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COMMUNICATION

How does your child communicate?

□ Verbal	□ Picture Exchange System	□ Sign Language
□ AAC Device	□ Gestures/Signs/Leads you	□ Other

Please describe your child's communication abilities:

1. How well do you and a stranger understand your child when he/she communicates (completely, somewhat, not very well).

2. Can your child follow simple one step instructions?

3. Describe how your child communicates his/her needs to you.

4. If using an AAC device, what system are they using (i.e. Prologuo2Go, Go Talk etc..).

5. What are your goals for your child's communication during this program?

DAILY LIVING SKILLS

Is your child toilet trained? □ Fully □ Partially □ No

Does your child need assistance with wiping themselves?	Yes ◯	No ◯
Does your child ask to go to the bathroom on their own?	Yes ◯	No ◯
Does your child need reminders to go to the bathroom?	Yes ◯	No ◯
What is your child' toileting schedule (i.e. once every 2 hours, once every 3 hours etc…)		

What is the frequency of daytime accidents □ never □ rarely □ 1-2x per day □ 3+ times per day

Does your child need help with dressing? (outdoor clothing, putting their shoes on etc..). If yes, what help do they need?	Yes ◯	No ◯

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Does your child need help with feeding? If yes, what help do they need:	Yes ◯	No ◯
Does your child have sleep difficulties?	Yes ◯	No ◯
Is there anything else that you would like to tell us that is pertinent to daily living skills? Please describe.		

SENSORY		
Does your child have sensory difficulties? (i.e. does not like bright lights, tags on clothing etc..)	Yes ◯	No ◯
Does your child resist if you physically support them (i.e. to draw, to walk, to wash hands etc..)	Yes ◯	No ◯
Does your child engage in repetitive behaviors (i.e. finger play, spinning items, twirling hair etc).	Yes ◯	No ◯
Have you noticed any deficits/sensitivities in: hearing/vision/other senses (i.e. does not like loud sounds, does not like the feel of play doh, obsessed with water etc..).	Yes ◯	No ◯
Is your child over-stimulated by noise/lights/crowds?	Yes ◯	No ◯
Is there anything else that you would like to tell us that is pertinent to your child's sensory skills? Please describe.		

BEHAVIOURS		
Does your child have any behavioral issues/behavior management issues? Please describe in the box below.	Yes ◯	No ◯
Is your child anxious? If yes, please list any triggers and how he/she demonstrates this.	Yes ◯	No ◯
Does your child have any current behavior plans/protocols?	Yes ◯	No ◯
Does your child engage in the following behaviors?		
Bolting (Running Away)	Yes ◯	No ◯

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Self-Injurious Behaviors (hitting themselves, pinching themselves, slamming themselves on the floor etc..)	Yes ◯	No ◯
Aggression toward others (hitting, pinching, slapping, hair pulling etc..)	Yes ◯	No ◯
Tantrums (Please describe)	Yes ◯	No ◯
Eating inedible and/or dangerous objects	Yes ◯	No ◯
Rigidities with routines	Yes ◯	No ◯
Does your child demonstrate fear of an activity/item? Please explain below.	Yes ◯	No ◯
Is there anything else that you would like to tell us that is pertinent to your child's behavior? Please describe.		

MOTOR SKILLS		
Does your child walk independently? (If they need assistance, please describe below).	Yes ◯	No ◯
Can your child walk independently up and down stairs? (If they need assistance, please describe below).	Yes ◯	No ◯
Does your child hop on one foot?	Yes ◯	No ◯
Does your child hop on two feet?	Yes ◯	No ◯
Does your child need support to stand?	Yes ◯	No ◯
Does your child complete simple activities that involve fine motor movements independently? (i.e. buttoning, threading, zipping, pointing, etc.…).	Yes ◯	No ◯
Can your child play catch with another person? (i.e. passing, catching, throwing a ball)	Yes ◯	No ◯
Is there anything else that you would like to tell us that is pertinent to your child's motor skills? Please describe.		

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ACADEMIC SKILLS		
Does your child need help with crafts? (i.e. glue stick use, scissors, etc..)	Yes ◯	No ◯
Can your child write independently?	Yes ◯	No ◯
Can your child read independently?	Yes ◯	No ◯
Can your child work productively in a small group?	Yes ◯	No ◯
Is there anything else that you would like to tell us that is pertinent to your child's academic skills? Please describe.		

SOCIAL SKILLS		
Does your child respond to his/her name?	Yes ◯	No ◯
Does your child make eye contact when communicating with you?	Yes ◯	No ◯
Does your child accept losing appropriately in board games?	Yes ◯	No ◯
Does your child take turns with others appropriately?	Yes ◯	No ◯
Does your child interact with other peers?	Yes ◯	No ◯
Please describe in detail how your child interacts with others, what some challenges are, and what some strengths are in this area.		

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MEDICAL NEEDS		
Does your child have any allergies?	Yes ◯	No ◯
Does your child have seizures?	Yes ◯	No ◯
Does your child take any medications?	Yes ◯	No ◯
Does your child need an epi-pen?	Yes ◯	No ◯

Please describe in **detail** any medical needs that your child has and how they are managed. If your child does not have any medical needs, please write N/A in the box below.

OTHER

Is there any other information that you would like to provide? Do you have any questions?

Parent Signature: _____ Date: _____