Avalon Employment Inc.

REFERRAL FORM

JOB SEEKER INFORMATION

Last Name: _____ **First Name:** _____

Date of Birth: _____

Address:

_____

Street Address *Apartment/Unit #*

_____

City *Province* *Postal Code*

Phone: _____ **Email:** _____

PARENT/GUARDIAN INFORMATION

Last Name: _____ **First Name:** _____

Phone: _____ **Email:** _____

Relationship to Job Seeker: _____

REFERRAL CRITERIA

Disability or Diagnosis (check all that apply):

☐ **Intellectual Disability** ☐ **Autism Spectrum Disorder**

Have any assessments been completed?
No ☐ Yes ☐ *(if yes, please attach)*

The following criteria must be provided to Avalon Employment prior to the initial intake:

- Must be 18 years or older; and,
- Copy of SIN, MCP, and/or Birth Certificate.

Verification of Diagnosis:

- Written documentation from a registered professional (i.e., physician or registered psychologist) that verifies a primary diagnosis of Autism Spectrum Disorder or Intellectual Disability.

REFERRED BY

Last Name: _____ **First Name:** _____

Self ☐ **School** ☐ **Doctor** ☐ **Other**
_____

Phone: _____ **Email:** _____

DATE OF REFERRAL

(YYYY/MM/DD): _____

Submit your referral to us via email or fax:

Email: services@avalonemploy.com | Phone: 1 (709) 579-4866 | Fax: 1 (709) 579-4892