# Diagnostic Assessment Referral

Date of Referral:____________________________

1. Name of person being referred:________________________________________________
(Surname) (Given Names)

Gender: M / F / Other (please specify):________________________________________________

Date of birth:________________________________Age at referral:________________________

Address:________________________________________________________Post Code: _______

Telephone:______________________________________________________________________
(Home) (Work) (Mobile)

Email:__________________________________________________________________________

Preferred method of contact (telephone, email, post): ____________________________________

Day Activity:____________________________________________________________________
(including name of school or child care centre if applicable)

2. If appropriate:
Parent/Carer(s): _________________________________________________________________
(mother) (father)

OR
Legal Guardian: _________________________________________________________________

Address: _______________________________________________________________________

______________________________________________________Post Code: _________________

Telephone:______________________________________________________________________
(Home) (Work) (Mobile)

Email:__________________________________________________________________________

3. Referring person: ________________________________________________________________

Agency:_________________________________________________________________________

Address: _______________________________________________________________________

________________________________________________________________________________

Telephone:_________________________________Fax: ____________________________________

4. Signature of person completing this form: ____________________________________________

**Referral continues on next page**

**Outline examples of behaviour and responses that are causing concern in the following areas.**

5. Socialisation: (e.g. response to family, peers, significant others, ability or interest in making friends, empathy, understanding of emotions in self and others)

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6. Communication (Verbal and Non Verbal): (e.g. use of gesture, facial expressions and eye contact; development of language, abnormality in content of language; imaginative ability)

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7. Restricted Range of Interests/Resistance To Change: (e.g. play activities/interests; issues with change; development of routines; preoccupations with objects, activities or behaviours; unusual motor movements, over or under reactions to sensory input)

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**Referral continues on next page**

8. Additional Information:

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Activities that the person is resistant to:

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Activities that the person really enjoys:

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9. Include copies of assessments: i.e. Speech Pathology; Occupational Therapy; Psychology.

**10. Please Send To:**

Senior Clinician Diagnostic Services
Autism SA
PO Box 556
MELROSE PARK DC SA 5039

Email: diagnostics@autismsa.org.au