



Diagnostic Assessment Referral

1. Child: _____
(Surname) (Given Names)

Date of Referral: _____

Parents: _____
(Mother) (Father)

Legal guardian (if other): _____

Date of birth: _____ Age at referral: _____

Address: _____
_____ Post Code: _____

Telephone: _____
(Home) (Work) (Mobile)

Kindergarten/School/Child Care Centre: _____

2. Referring person: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Outline examples of behaviour and responses that are causing concern in the areas of (if not enough space please attach sheets with additional information):

3. Socialisation: (e.g.)

Response to family, peers, significant others; imitation skills; play skills; awareness of self and others; ability or interest in making friends.

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Endorsed by Management: July 2007	Due for Review: July 2009
Signed: <i>Amanda Harris</i>	G:\DA\DA Forms\DA FI - DA Referral.doc

Socialisation (continued): _____

4. Communication (Verbal and Non Verbal): (e.g.)

Mode of communication; use of gesture, facial expression; eye contact to people and objects; imaginative ability; abnormalities in content e.g. echolalia; repetitive speech; use of monotone voice; lengthy monologues on a particular topic.

5. Restricted Range of Interests/Resistance To Change: (e.g.)

Play activities; obsessions; excessive mouthing, touching, smelling; insistence on following routes e.g. to and from shops; distress in changes in environment; preoccupation with one narrow interest; obsessions with maps, yellow pages, adverts, television programs etc.; attachment to unusual objects e.g. twigs.

Restricted Range of Interests/Resistance To Change (continued): _____

6. Additional Information (if not enough space please attach additional sheets):

Activities that the child/person is resistant to:

Activities that the child/person really enjoys:

7. Include Copies Of Recent Assessments:

Speech Pathology; Occupational Therapy; Psychology.

8. Please Send To:

Coordinator Diagnostic Services
Autism SA
PO Box 304
MARLESTON DC SA 5033