



# Diagnostic Assessment Referral Adult

1. Name: \_\_\_\_\_  
(Surname) (Given Names)

Date of Referral: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age at referral: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Post Code: \_\_\_\_\_

Telephone: \_\_\_\_\_  
(Home) (Work) (Mobile)

Day Activity: \_\_\_\_\_

Parents/ Legal Guardian / Carer (if appropriate): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Post Code: \_\_\_\_\_

Telephone: \_\_\_\_\_  
(Home) (Work) (Mobile)

2. Referring person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Outline examples of behaviour and responses that are causing concern in the following areas. Please note that as part of the diagnostic assessment process a detailed questionnaire will be forwarded to the individual being assessed, and there will be an opportunity to expand on the points listed below.**

3. Socialisation: (e.g.)

\_\_\_\_\_

\_\_\_\_\_

|                                   |  |
|-----------------------------------|--|
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| Signed: Amanda Harris             | G:\DA\DA Forms\DA F14 - Referral Form Adult.doc                  |

Socialisation (continued): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

6. Additional Information

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

**Please Send To:**

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