



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)

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)

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)

- 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)

- 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)

Referral continues on next page

8. Additional Information:

Activities that the person is resistant to:

Activities that the person really enjoys:

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

10. Please Send To:

Senior Clinician Diagnostic Services
Autism SA
PO Box 304
MARLESTON DC SA 5033