NEURO DIVERSITY CENTRE

REFERRAL FORM

Personal details of referred individual:

Name and Surname:

Date of birth:

Y	Y	Y	Y		M	M		D	D

School: _____ Grade: _____ Any Grade Repeated: Y / N

Full name and contact details of Parent/Guardian 1:

Cell number:

Email address:

Full name and contact details of Parent/Guardian 2:

Cell number:

Email address:

Have parent(s) been informed about the present referral? Y N

What reason has been provided to parents / guardians for present referral?

Other professionals involved:

Psychiatrist: Y N If yes, name and ✆:

Psychologist: Y N If yes, name and ✆:

OT	SLT	ST	Physio

**If yes, indicate with whom and duration:

Lekkerwijn Estate
Junction of R45 and R301
Groot Drakenstein
7680

Oxford Gate (Block A1)
54 Oxford Street
Durbanville
7550

24 Fairbairn Street
Worcester
6850

94 Lourensford Rd
Somerset-West
7130

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Existing diagnosis: Y | N

If yes, please provide diagnosis: _____

_____

_____

Medication: Y | N

Medication	Dosage	Duration on medication

Reason for referral (please tick):

- ◯ Diagnostic Assessment only
- ◯ Post-diagnostic support and intervention
- ◯ Diagnostic Assessment and further management
- ◯ Other (please specify): _____

Background to referral / other comments:

Date of Referral: yyyy / mm / dd

Referrer: _____ _____ _____

Name & Surname Profession Signature

**Kindly attach any relevant reports or documents you feel could assist in the referral

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