

## External Referral Form

Autism Spectrum Disorder Initiatives



**AutismInitiativesGroup**  
*real partnerships, unique solutions, positive outcomes.*

|                   |  |                    |  |
|-------------------|--|--------------------|--|
| Name:             |  | DOB:               |  |
| Parent/guardian1: |  | Parent/guardian 2: |  |
| Phone:            |  | Email:             |  |
| Address:          |  |                    |  |

|   |  |
|---|--|
| Referral Source:                              |  |
| Reason for referral:                          |  |
| Diagnosis:                                    |  |
| Diagnosis Information<br>(date, by whom etc): |  |
| Relevant medical<br>information:              |  |
| Services received to<br>date:                 |  |
| Education history:                            |  |

|   |  |          |  |
|---|--|----------|--|
| Has consent for referral been given:      | Yes <input type="checkbox"/> No <input type="checkbox"/> | By whom: |  |
| Name and position of person<br>referring: |  |          |  |
| Signed by person referring:               |  | Date:    |  |
| Phone:                                    |  | Email:   |  |
| Address:                                  |  |          |  |

All reports pertaining to this referral are required prior to commencement of the assessment and compatibility review process. Please attach the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Psychological report | <input type="checkbox"/> Speech and Language Therapy Report |
| <input type="checkbox"/> Psychiatric Report   | <input type="checkbox"/> Occupational Therapy Report        |
|   | <input type="checkbox"/> 3 Month Incident reports           |

Please return to: Autism Initiatives, Block 1, Newtown Business & Enterprise Park,  
Newtownmountkenedy, County Wicklow