



## Request Form for Outreach services

Date: \_\_\_\_\_

Referred by DHB \_\_\_\_\_  
Self-referral \_\_\_\_\_  
Other \_\_\_\_\_

### Childs Details

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_ Year: \_\_\_\_\_

Ethnic Group: \_\_\_\_\_

### Parents/Caregivers Details

Full Names: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

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

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### Primary Health Organisation details (If applicable):

Name: \_\_\_\_\_

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

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### Reasons for requesting Outreach services:

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

Please tick if the following are concerns:

Sensory Issues  School:  Behaviour:  Activities:  Other:

Children's Autism Foundation Programmes that you are interested in:

Stepping Stones  Join in:  Workshops  Outreach  Other

Would you like to receive regular monthly newsletter from the Children's Autism Foundation?

Children's Autism Foundation  
PO Box 301 220, Albany,  
Auckland 0752

enquiry@autism.org.nz www.autism.org.nz ph: (09) 415 7406