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:

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Referring agency - have you obtained permission from parent/guardian for this referral? Delete one: YES / NO

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? ☐

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