GOVERNMENT OF WESTERN AUSTRALIA

The Department of Communities (Communities)

Referral form for Diagnostic Assessment for Neurodevelopmental Disability (including Intellectual Disability and Autism Spectrum Disorder)

Please complete this form and return to:

Department of Communities
Neurodevelopmental Disability Assessment Service
Locked Bag 5000
FREMANTLE WA 6959

Fax : 6155 9371
Email : assessment@communities.wa.gov.au

Please contact the team on 0435 047 968 or 0435 048 136 if you require any assistance with completing this referral form.

Section A: Details of the individual being referred

Surname			
First name		Other name(s)	
Date of birth		Gender: ☐ Male ☐ Female ☐ Unspecified	
Address			
Postal address (if different to above)			
Telephone	H:	M:	
Country of birth:			
Is the applicant of Aboriginal or Torres Strait Islander descent?		Y	N
Does the applicant speak a language other than English?		Y	N
If **yes,** what other language(s) does the applicant speak? (eg Vietnamese, Italian, AUSLAN)			
Is an interpreter required for the applicant and/or parents/guardians?		Y	N
Does the applicant identify as being from a culturally and linguistically diverse (CALD) background?		Y	N

Section B: Reason for referral

Please tick appropriate boxes

☐ Diagnostic assessment for Intellectual Disability
☐ Diagnostic assessment for Autism Spectrum Disorder

Section C: Details about the applicant's parent(s)/guardian(s)

Are the parents the applicant's legal guardians? YES NO

Please provide a copy of the **appropriate guardianship order:**
If the applicant is a child (under 18 years of age), is there a:

☐ Parenting order? (if applicable, a copy is required)
☐ Protection order? (if applicable, a copy is required)

	Parent/Guardian **(1)**	Parent/Guardian **(2)**
Relationship		
Surname		
First names		
Address		
Postal address (if different to above)		
Telephone	H:	H:
	M:	M:
Email		

Section D: Details of the referring person

Name		
Position / Title		
Agency (if applicable)		
Address		
Postal address (if different to above)		
Phone/fax	W:	M:
	H:	Fax:
Email		

Section E: Consent and information (please tick)

☐ Y ☐ N I consent to an assessment by a psychologist and/or speech pathologist to determine if the referred individual has Autism Spectrum Disorder, Intellectual Disability and/or other neurodevelopmental disorders.

☐ Y ☐ N I consent to Communities obtaining information that may assist with this referral from agencies/professionals listed below.

Agency/professional's name	Address	Phone	Fax

☐ Y ☐ N I consent to the diagnostic outcome being shared with the Department of Education / The Association of Independent Schools of WA / Catholic Education of WA, where applicable.

Please note that the diagnostic assessment services are not intended to inform medico-legal proceedings.

Parents/legal guardians to sign this consent form. If the applicant is over 18 years, the applicant will also need to sign this form.

I have read the above or had the above explained to me, I understand, and I give my consent.

Name:		Signature	
Relationship to applicant		Date	
Name:		Signature	
Relationship to applicant		Date	
Name of applicant		Reference number (if known)	