



Waiora Tamariki

WELL-BEING SUPPORT FOR AUTISTIC CHILDREN AND THEIR PARENTS

Referral Form

Date: _____

CHILD'S DETAILS

Surname:

First names:

Gender:

Date of Birth:

Age:

PARENTS' / CAREGIVERS' DETAILS

Surname:

First names:

Date of Birth:

Address:

Contact Email:

Contact number:

(H)

(M)

Relationship with child:

Surname:

First names:

Date of Birth:

Address:

Contact Email:

Contact Number(s):

(H)

(M)

Relationship with child:

Associate Professor Laurie McLay

University of Canterbury,
Rehua Building, Level Two,
Christchurch 8140

Phone: (03) 369 3522

Email: laurie.mclay@canterbury.ac.nz

Referral Form

REFERRER'S DETAILS (If not a self-referral)

Name:

Role:

Organisation/Agency:

Contact Phone:

Contact Email:

Clinical Information

Eating/feeding challenges - reason for referral:

Clinical History (e.g. diagnosis, medications, strategies tried etc):

Other Relevant Information:

Please return this form via email or post.

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