UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

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

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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
Toileting 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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