# Sydney Child Assessment Centre

**REFERRAL FORM**

## The Pupil's Details

The pupil's first name: _____

The pupil's surname: _____

The pupil's gender: Male ☐ Female ☐

The pupil's date of birth: / / (dd/mm/yyyy)

## Your School's Details

Name of your school: _____

Name of referring teacher: _____

Phone contact if necessary: _____

Email for report: _____

Please indicate the pupil's special educational needs as known/suspected by your school. Please tick the relevant box or boxes:

| | | | | | |
|---|---|---|---|---|---|
| A | Cognitive/Learning Difficulties | ☐ | B | Sensory Difficulties (Vision and/or Hearing) | ☐ |
| C | Communication and Interaction Difficulty | ☐ | D | Physical Difficulties | ☐ |
| E | Social, Emotional and/or Behavioural Difficulties | ☐ | F | Medical Difficulties | ☐ |
| G | Other Special Educational Need(s) *Please specify below* | ☐ | | | |

## Reasons for Referral

Please give brief details of the nature of the child's difficulties/progress prompting this referral:

Is there anything you particularly hope to learn as a result of this referral?

Use over page if necessary

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