NEURO DIVERSITY CENTRE

CAPE TOWN | GREEN POINT | 49 SOMERSET ROAD ☎ 021 462 1508
DURBANVILLE | OXFORD GATE (BLOCK A1) | 54 OXFORD STREET ☎ 021 975 0376
GROOT DRAKENSTEIN | LEKKERWIJN ESTATE | JUNCTION OF R45 & R301 ☎ 021 200 8327
HERMANUS | XPEDIENT HOUSE | 4 DIRKIE UYS STREET ☎ 021 975 0376
SOMERSET-WEST | 24 BRIGHT STREET ☎ 021 850 0004
STELLENBOSCH | 33 HERTE STREET ☎ 021 975 0376
WORCESTER | 53 RIEBEECK STREET ☎ 021 975 0376

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Pr no: 0669334
☎ For general enquiries and referrals 021 975 0376
practicemanager@neurodiversitycentre.co.za

REFERRAL FORM

Personal details of referred individual:

Name and Surname:

Date of birth: Y Y Y Y M M D D

Area of Residence

School: _____ Grade: _____ Any Grade Repeated: Y / N

Full name and contact details of Parent/Guardian 1:

Cell number:

Email address:

Full name and contact details of Parent/Guardian 2:

Cell number:

Email address:

Have parent(s) been informed about the present referral? Y N

What reason has been provided to parents / guardians for present referral?

Other professionals involved:

Psychiatrist: Y N If yes, name and ✆:

Psychologist: Y N If yes, name and ✆:

OT | SLT | ST | Physio **If yes, indicate with whom and duration:

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Existing diagnosis: Y | N

If yes, please provide diagnosis: _____

_____

_____

Medication: Y | N

Medication	Dosage	Duration on medication

Reason for referral (please tick):

- ◯ Diagnostic Assessment only
- ◯ Post-diagnostic support and intervention
- ◯ Diagnostic Assessment and further management
- ◯ Cognitive and / or Scholastic assessment
- ◯ Other (please specify): _____

Kindly indicate Medical Aid of Client:

- Discovery ☐
- Bonitas ☐
- Momentum ☐
- MediHelp ☐
- GEMS ☐
- Keyhealth ☐
- Profmed ☐
- Other:_____

Background to referral / other comments:

Date of Referral: yyyy / mm / dd

Referrer: _____ _____ _____

Name & Surname Profession Signature

**Kindly attach any relevant reports or documents you feel could assist in the referral