Clinical Psychology Centre

Child Cognitive Assessment Referral Form

Child Details	
Child's Name:	Date of Birth:
Address:	
	Postcode:
Parent/Caregiver Name:	
Home Phone:	Work Phone:
Cell Phone:	Email:

School Details	
School:	
Address:	Phone:
	Fax:
	Current Teacher:
Email:	

Referral Agent Details	
Name:	Agency:
Address:	Phone:
	Fax:
Email:	
Signature:	Date:

Department of Psychology – Clinical Psychology Centre
PO Box 56, Dunedin 9054, New Zealand
Telephone: 03 479 7627 . Fax: 03 479 6838

Reason for Referral:
Please include relevant information (e.g. academic, behavioural difficulties, etc), and any relevant previous assessment details (e.g. reading assessments, school reports, etc)

Please continue on a separate sheet if necessary

Details of Prior Cognitive Assessment:
Please complete if a prior cognitive assessment has taken place for this child, and include a copy of the report, if available

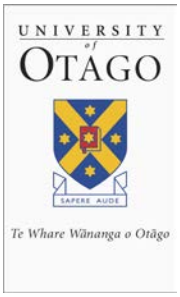
Date of Prior Cognitive Assessment:

Name of Assessor:

Agency:

Address:

Phone Number:



Clinical Psychology Centre

Parental/Caregiver Consent

I . . . . . give permission for . . . . . .
(Parent/Caregiver Name) (Referrer's Name)

to make this referral to the Clinical Psychology Centre for . . . . . .
(Child's Name)

Signed:_____

Date: _____

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