

Please note: This is not a referral form

WHIRINAKI

Child and Adolescent Service

Private Bag 93311

Otahuhu

Auckland

Email: whirinaki@middlemore.co.nz

Telephone:

09 265 4000

Fax:

09 265 4199

Dear Principal

We have received a referral and are seeking this information to assist with our assessment.

Full name of student:	Date of birth:
	Age:
School:	Teacher:
Year:	Number in Class:
Admission date - current school:	Number of schools attended:

ACADEMIC PROGRESS: (Please give results of the student's latest learning assessments and indicate how he/she compares with pupils of the same age. Indicate if there has been any significant loss of skills or regression).

General Ability:

Reading:

Writing:

Spelling:

Mathematics:

Other subjects & activities: e.g. art, music, sports (only comment if special strengths or weaknesses)

GENERAL SCHOOL BEHAVIOUR: e.g., attitudes to teachers and schoolwork, response to rules and discipline

Name of child:

RELATIONSHIPS WITH OTHER CHILDREN: e.g. interest and success in relating to own age group, ability to join in group activities and play, friendships, social confidence

In the playground:

In the classroom:

MOTOR SKILLS: Gross motor - running, jumping etc:	satisfactory / concerns
Fine motor – eye-hand coordination:	satisfactory / concerns
Hand writing	satisfactory / concerns

Medical conditions noted on school record cards:		
Hearing Tested?	Date:	Result:
Vision Tested?	Date:	Result:

Absences from: School Occasional / Frequent ___ half-days/term

AGENCY INVOLVEMENT Please indicate if current (C) or past (P)		
GSE Name:	RTLB Name:	Teacher Aide Name:
Speech Therapist Name:	PH Nurse Name:	Other: Name and role:

Additional Comments/ Concerns	
Signed.....	Date.....
Print Name:.....	
Designation:.....	
PLEASE RETURN FORM TO: _____	
Key Worker/Clinician Koru Team Whirinaki	

Thank you very much for your help

Please Note: We have already received a referral for this child. We are seeking additional information to assist us with our assessment.