Government of **Western Australia**
Department of **Communities**

Clear form

Diagnostic Assessment of Intellectual Disability and Autism Spectrum Disorder

Consent form

Please complete this form and return to:

Department of Communities
Neurodevelopmental Disability Assessment Service
Locked Bag 5000 FREMANTLE WA 6959
Fax: 6155 9371 Email: assessment@communities.wa.gov.au

Please contact the team on **6414 1444** if you require any assistance with completing this form.

Section A: Details of the applicant / individual being referred

Surname

First name/s

Other name/s

Date of Birth

Gender

Male ☐ Female ☐ Unspecified ☐

Contact number/s

Home: Mobile:

Residential address

Postal address (if different to residential)

Country of birth

Is the applicant of Aboriginal or Torres Strait Islander descent? Yes ☐ No ☐

Does the applicant speak a language other than English? Yes ☐ No ☐

If yes, what other language(s) does the applicant speak? (eg Vietnamese, Italian, AUSLAN)

Is an interpreter required for the applicant and/or parents/guardians? Yes ☐ No ☐

Does the applicant identify as being from a culturally and linguistically diverse (CALD) background? Yes ☐ No ☐

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Section B: Reason for referral

Please tick appropriate boxes:

- ☐ Diagnostic assessment for Intellectual Disability
- ☐ Diagnostic assessment for Autism Spectrum Disorder

Section C: Details about the applicant's parent(s)/guardian(s)

Are the parents the applicant's legal guardians? Yes ☐ No ☐

Please provide a copy of the **appropriate guardianship order**. If the applicant is a child (under 18 years of age), is there a:

- ☐ Parenting order? (if applicable, a copy is required)
- ☐ Protection order? (if applicable, a copy is required)

Parent / Guardian 1

Surname

First name/s

Relationship

Contact number/s

Home: Mobile:

Residential address

Postal address (if different to residential)

Email

Parent / Guardian 2

Surname

First name/s

Relationship

Contact number/s

Home: Mobile:

Residential address

Postal address (if different to residential)

Email

Section D: Details of the referring person

Name

Position / title

Agency

Address

Postal address (if different to above)

Contact number/s

Home:	Mobile:
Work:	Fax:

Email

Section E: Consent and information

I consent to an assessment by a psychologist and/or speech pathologist to determine if the referred individual has Autism Spectrum Disorder or Intellectual Disability.

Yes ☐ No ☐

I consent to Communities obtaining information that may assist with this referral from agencies/professionals listed below (It may be helpful to include current medical, allied health professional and school contact details).

Yes ☐ No ☐

Agency/ Professional's name 1

Address

Phone: Fax:

Agency/ Professional's name 2

Address

Phone: Fax:

Section E: Consent and information (continued)

Agency/ Professional's name 3

Address

Phone:

Fax:

I consent to the diagnostic outcome being shared with the Department of Education / The Association of Independent Schools of WA / Catholic Education of WA, where applicable.

Yes ☐ No ☐

Please note that the diagnostic assessment services are not intended to inform medico-legal proceedings.

Parents / legal guardians to sign this consent form.

If the applicant is over 18 years, the applicant will also need to sign this form.

I have read the above or had the above explained to me, I understand, and I give my consent.

Parent Guardian 1 (print name)

Signature

Relationship to applicant:

Date:

Parent Guardian 2 (print name)

Signature

Relationship to applicant:

Date:

Name of applicant (print name)

Reference number (if known)

Applicant's signature (if over 18 years)