النــجـــوم للــقـــدرات الخـــاصـــة
Stars for Special Abilities

Adult Referral Form for Therapy Services

Please note some questions are asked for an either "yes" or "no" response: where appropriate please give a description or details to these questions. Space is provided for you to do so. Thank you.

Date: day……….month……………..year………...
Name of Client...

If someone other than the client is completing the form, please state name and relationship to client:
...

DOB: day……….month……………..year………..

Developmental History
As far as you are aware did you meet all developmental milestones on target? ....
....
....
Are you right or left handed? **Right / Left (**circle as appropriate) ....
Do you have any difficulties with co-ordination? ....
....
....
Are there any everyday activities you have difficulty with? ....
....

Have you ever had difficulty with the following areas prior to today?
Please check/tick the box as appropriate:

☐speech pronunciation	☐understanding	☐expressing	☐reading	☐memory
☐mathematics	☐attention difficulty	☐social interaction	☐writing	☐problem solving
☐gross motor skills	☐fine motor skills	☐hearing loss	☐stuttering	☐other

If the answer to any of the above is yes, please describe: ....
....

<u>Diet</u>
Do you have any difficulties eating or drinking? ....
....
....
....
Do you have a healthy diet? ....
What food do you eat/enjoy? ....
....
....
....
What food do you dislike/avoid? ....
....

....
....

MEDICAL HISTORY

Health

Family Doctor: ....
Contact details: ....
Do you have:
Known medical diagnosis: ❑ No ❑ Yes; if yes please describe:..
....
....
Are you taking any medication? ❑ No ❑ Yes; if yes please provide the name and the dosage:
....

Hearing /Vision

Do you have a hearing impairment? ....
Have you any concerns about your hearing? ....
....
Do you wear/need a hearing aid? ....
To the best of your knowledge do you:

- Talk in a very loud voice ....
- Turn up the volume very loud ....
- Not hear people if you can't see them...
- Have a history of ear infections ....
- Have unusual reactions to loud noises...

Do you have any visual difficulties? ....
Do you wear/need glasses? ....
Are you concerned about your eyesight? ....
To the best of your knowledge do you:

- Have burning, itching, watering eyes..
- Squint one or both eyes while watching television ....
- Tilt head or close an eye while reading/looking at pictures/objects...
- Get headaches while reading or writing ....
- Frequently bump into things, or knock things over ....
- Have difficulty following words on a page..
- Give up easily on work, thinking, "I can't" before trying ....

Therapy

Have you ever been referred to any of the following specialists? (tick/check those that apply)
☐Audiologist ☐Otolaryngologist (ENT) ☐Gastroenterologist ☐Speech & Language Therapist
☐Psychologist ☐Optometrist ☐Psychiatrist ☐Occupational Therapist ☐Physiotherapist
☐Psychomotor Therapist ☐Neurologist ☐Other :..
If yes, please state the reason and results: ....
....

Stars for Special Abilities – Enhancing Life Experiences – Developing Abilities

Educational History

Please tick/check as appropriate

☐Primary/Elementary School ☐Secondary/High School ☐Undergraduate ☐Post Graduate

Degree(s): ....

Name of Institution/s for highest education levels only: ....

Work History

Are you currently employed? **Yes /No** (please circle as appropriate and complete details below)

Occupation/s: ....

....

....

Place/s of Employment: ....

....

Most recent job duties: ....

Date of Retirement: .... Reason: ....

Are you currently driving? **Yes/ No**

Please describe any other factors you think may be relevant ....

....

....

....

....

Thank you for completing this form. Please submit this form to Stars for Special Abilities who will then contact you for an appointment at the earliest available opportunity.

The information contained in this form is confidential and will not be distributed without your consent. Please be sure to provide any relevant reports and information prior to your appointment.

We look forward to working with you.

Thank you.

❑ *I confirm that I have received Stars policy and agree will the terms and conditions therein.*

Signature:	Date:
Signature:	Date:

Stars for Special Abilities
Developing Abilities, Enhancing Life Experiences