النجوم للقدرات الخاصة
Stars for Special Abilities

Please affix passport-sized photo of child here

Child Referral Form for Therapy Services

Date: _______________ *dd month year (in full please)*

Child's name: _______________ Birth date: _______________

Age: _______ Gender: F M Nationality: _______________

First Language: _______________ Second Language: _______________

Grade: _______________ School/Nursery: _______________

Mother's Name: _______________ Father's Name: _______________

Age: _______________ Age: _______________

Occupation: _______________ Occupation: _______________

Mobile Number: _______________ Mobile Number: _______________

Email: _______________ Email: _______________

Home number: _______________ Best time to call: _______________

Form completed by: _______________ Relationship to child: _______________

Referred by: _______________

Reason for referral: _______________

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What does your child have difficulty with?

Communication			
☐ talking	☐expressing self	☐speech pronunciation	
☐stuttering	☐understanding	☐hearing loss	
Education			
☐writing	☐reading	☐maths	☐memory
☐learning	☐school		
General Development			
☐emotional	☐attention	☐ social interaction	☐playing
☐behaviour	☐feeding	☐memory	
Motor and Sensory			
☐gross motor skills, e.g. walking, sitting, jumping		☐fine motor skills, e.g. hand movements	
☐self-help skills, e.g. dressing, washing		☐sensory problems(tactile, movement, visual, auditory)	
☐other:			

Does your child have a diagnosis? ☐No ☐Yes If yes, please specify: e.g. Epilepsy, Diabetes etc.

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Stars for Special Abilities
Developing Abilities, Enhancing Life Experiences

Does your child take any medication? ☐No ☐Yes If yes, please give names and dosages:

Has your child received previous services?

What?	**Where?**	**How long?**
Speech & Language Therapy (SLT)		
Psychology (PSY)		
Occupational Therapy (OT)		
Psychomotor Therapy (PMT)		
Physio-therapy		
ABA		
Special Education (SE)		

Please mention the type of assessment requested if any.

☐SLT ☐OT ☐PMT ☐PSY ☐SE ☐Psycho-Educational ☐Multidisciplinary ☐Early Intervention

☐Other: ________________________

Preferred language for services: ☐ English ☐ Arabic ☐ French ☐Other: ____________________

Developmental History

We are aware that we are asking for a lot of information, which is why we are giving it to you to take home so that you have a bit of time to think it through. Please don't worry if you cannot remember exact ages or details; what we are most interested in is whether or not you had concerns or comments about any of the items below, e.g. was your child late or early with anything. This information is important for us to fully understand your child's profile.

Birth History

Were there any complications during pregnancy? ☐ No ☐ Yes

Diabetes		Rubella		Pre-Eclampsia		Medication	
Anaemia		Toxoplasmosis		Eclampsia			
Accident		Other					

Birth

Vaginal		Scheduled C-Section		Emergency C-Section		Forceps		Ventouses	

Length of pregnancy		Birth weight	

Were there any complications at or after your child's birth?☐ No ☐ Yes

Jaundiced		Blue		Lack of oxygen		Foetal distress	
Other							

Developmental Milestones (WTL= Within Time Limits)

	Age	**WTL/Early/Late**		**Age**	**WTL/Early/Late**
Rolled over			Eye gaze face		

Sat alone			Localize sound		
Crawled			Startle loud noise		
Stood			Eye gaze object		
Walked			Grasped Object		
Ran			Gave object		
Stairs up			Stairs down		
Self Help Skills	**Age**	**WTL/Early/Late**		**Age**	**WTL/Early/Late**
Fed self with fingers			Dressed: help		
Fed self: spoon			Dressed: alone		
Fed self: fork			Removed clothes		
Fed self: knife			Buttons		
Drank: sippy cup			Tied shoes		
Drank: cup			Shower alone		
Drank: straw			Washed hands		

Gross Motor					
Jumped			Kick a ball		
Rode a tricycle			Throw a ball		
Rode a bike			Catch a ball		
Fine Motor					
Palmer (fist) grasp			Used scissors		
Pincer grasp			Colored in lines		
Tripod grasp			Printed name		
			Writing (reversals)		
Handedness:	Right	Left	Ambidextrous	Inconsistent	Not determined

Toileting:			**Frequency if relevant**
Toilet with help	Day	Night	
Toilet independent	Day	Night	
Bladder Control	Day	Night	
Bowel control	Day	Night	
Constipation	Yes	No	
Regular bowel movements	Yes	No	

Hearing /Vision

Hearing impairment? ❑ No ❑ Yes;	Cochlear implant? ❑ No ❑ Yes
Any concerns about his/her hearing? ❑ No ❑ Yes;	Turn up the volume very loud? ❑ No ❑ Yes
Grommets? ❑ No ❑ Yes	Have a history of ear infections? ❑ No ❑ Yes
Wear/need a hearing aid? ❑ No ❑ Yes	Have unusual reactions to loud noises? ❑ No ❑ Yes
Talk in a very loud voice? ❑ No ❑ Yes	Request Repetitions ❑ No ❑ Yes
Not appear to hear you if he can't see you? ❑ No ❑ Yes	Task related self-regulatory noises ❑ No ❑ Yes

Visual difficulties? ❑ No ❑ Yes; if yes please describe	Wear/need glasses? ❑ No ❑ Yes
Eyesight concerns? ❑ No ❑ Yes; if yes please describe	Eye surgery❑ No ❑ Yes
Have burning, itching, watering eyes? ❑ No ❑ Yes	Get headaches while reading or writing? ❑ No ❑ Yes
Demonstrate squinting one or both eyes while watching television? ❑ No ❑ Yes	Frequently bump into things, or knock things over? ❑ No ❑ Yes
Tilt head or close an eye while reading/looking at pictures/objects? ❑ No ❑ Yes	Unusual reaction to bright lights ❑ No ❑ Yes

Communication

How was your child as a baby?	Easy ❑ No ❑ Yes	Sociable ❑ No ❑ Yes	Passive ❑ No ❑ Yes
Active❑ No ❑ Yes	Quiet ❑ No ❑ Yes	Cried a lot ❑ No ❑ Yes	Demanded attention ❑ No ❑ Yes
Other: (Please describe)			
Did your child interact with others? ❑ No ❑ Yes	If yes, with whom (please tick below)?		
Parents ❑ No ❑ Yes	Siblings ❑ No ❑ Yes	Family ❑ No ❑ Yes	Peers ❑ No ❑ Yes
Nanny ❑ No ❑ Yes	Teachers ❑ No ❑ Yes	Family friends ❑ No ❑ Yes	Others ❑ No ❑ Yes
Age at which your child:	Cooed	Babbled	First words
Put 2/3 words together	Used sentences	Put sentences together	
Engaged in conversation	Understood directions	Pointed	
Sample of your child's first words:			
Other observations:			

Please describe the concerns you have regarding your child. Is there anything else you think it is important for us to know?

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Dear Parent/Career,

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 and your child.

Thank you.

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

❑ *I give permission to Stars to liaise with my child's school for relevant information and advice.*

Signature: Date:

Signature: Date: