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:

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.

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

Previous Surgery/Surgeries? ☐No ☐Yes If yes, please specify:

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

If yes please state:	

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

If yes, please state:	

Developmental Milestones (WTL= Within Time Limits)

Motor

	Age		**Age**
Rolled over			
Sat alone			
Crawled			
Stood			
Walked		Grasped Object	
Ran		Gave object	
Stairs up		Stairs down	
Self Help Skills	**Age**		**Age**
Fed self with fingers		Dressed: help	
Fed self: spoon		Dressed: alone	
Drank: sippy cup		Tied shoes	
Drank: cup			
Drank: straw			

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

Toileting:		
Toilet with help	Day	Night
Toilet independent	Day	Night

Hearing /Vision

Any concerns about his/her hearing? ❑ No ❑ Yes	Recent hearing test? ❑ No ❑ Yes
Grommets? ❑ No ❑ Yes	Have a history of ear infections? ❑ No ❑ Yes
Visual difficulties? ❑ No ❑ Yes; if yes please describe	Wear/need glasses? ❑ No ❑ Yes

Communication

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	
Does your child interact with others? ❑ No ❑ Yes			
Sample of your child's first words:			
Other observations/concerns:			

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

Dear Parent/Carer,

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:

STARS FOR SPECIAL ABILITIES and Early Intervention

Policies Acknowledgement and Signature Page

Refund Policy

For payments in advance, a minimum of 5 weeks from the date of the request applies in order to proceed with the refund. Refund requests are to be made via *Stars for Special Abilities* email: admin@starzuae.com.

Cancellation Policy

Appointments are to be regarded as a contract between *Stars for Special Abilities* and Parents for the exclusive use of the therapists' time.

All cancellations should be made at least 24 hours in advance by informing the Front Desk through phone or email at: admin@starzuae.com.

If notice has been given within less than 24 hours, the first cancellation will be charged half of the applicable rate. For the second cancellation and onwards, higher rates may apply.

For assessments cancelled within less than 24 hours, an extra fee of AED 150 will apply for rescheduling.

A minimum attendance of 80% is required to continue to receiving services from Stars for Special Abilities.

No-Show Policy

Appointments are to be regarded as a contract between *Stars for Special Abilities* and Parents for the exclusive use of the therapists' time.

If appointment is not attended (No-Show) without any prior notice, parents should be charged the full session rate.

Stars for Special Abilities reserves its right to consider refusing the services.

For assessments not attended without any prior notice, an extra fee of 250 AED will apply for rescheduling.

Services may be refused or discontinued due to non-payment, aggressive behavior or lack of cooperation.

By signing below, I acknowledge *Stars for Special Abilities* Refund, Cancellation, No-Show policies.

Patient Name:

Parent Name:

Date:

Signature: