Meeting the Needs of Families Living with Autism (NEMFLA)
REFERRAL FORM

Name/s of parent/s main carer/s:			
Name of child:	Child's DOB:	Child's gender M/F:	
Names of others living at home and relationship to child with ASD (please include siblings dates of birth)			
Borough of residence:			
Address: Telephone numbers: (home/work/mobile) Best time to contact:			
Child's diagnosis:	Date:		
Ethnic origin of parents:			
Marital Status	Married	Single	Lone parent
Language spoken at home	Preferred language	Interpreter required? Yes/No	
Other/s with parental responsibility and contact details:			
Other agencies involved with the family:			
Has the family agreed to this referral? Yes/No	Date of referral:		
Referral & Contact details Name: Designation: Department /organisation: Address: Telephone:			
Reason for referral (e.g. Recent diagnosis, behaviour, cultural issues etc)			
Any additional information? Please return to: **Family Support Worker** **St Michael Associates** **368 Old Kent Road SE1 5AA email: info@stmichaelassociates.org.uk tel/fax; 0207 7083939**			