GROWING UP WITH AUTISM

Registration Form

YOUNG PERSONS DETAILS					Today's date: / /	
NAME					Date of birth	/ /
NHI Number		Gender		Ethnicity		
What diagnosis does this young person have?						
Who made the diagnosis?						
Where was the diagnosis made and date?						Date: / /

PARENT/CAREGIVER DETAILS		
Name(s)	1.	Relationship to child:
	2.	Relationship to child:
Home Address:	Number/Street: Suburb: Town/city: Post code:	**Best daytime contact phone numbers:** Mobile phone: Home phone: Work phone:
E-mail address:		
Parent/caregiver first language:		

Session attendance
Growing up with Autism is a 20 week course specifically for parents and carers of adolescents aged between 11 and 16 years. See our website for **scheduled group sessions** and more information: www.idea.org.nz >Our Services>Autism Services **or** contact 0800 273 7587.

Location:	Group commencing on Date/Time:
City/Town:	Date: / / Day: Time:

To be filled in by Referrers only:

If this referral hasn't been filled in by a parent/guardian please provide all the following details: (**Referrer must have obtained parental/guardian consent to submit this referral)*

Referrer name:	Role:	Organisation:
Phone number:	E-mail:	
Signature:		Date: / /

Parental/Carer Permission: Confirmation of obtaining parents/carers permission: Yes ☐ / No ☐

Return completed referral form to:

- E-mail: GUWA@idea.org.nz
- Post: ASD Programme Coordinator, IDEA Services, PO Box 4155, Wellington 6140