

Circle of Security Group Program: For parents of children with additional needs

Referral/Registration Form

Child's Name: _____

Date of Birth: _____

Parent/Carer Contact: _____

Address:

Street _____

Suburb _____ State _____ Postcode _____

Home telephone: _____ Mobile telephone: _____

Email: _____

Child diagnoses and/or presenting concerns:

Relevant parental history/information

Ability to attend program – Please indicate which session the parents will be able to attend:

- Term 1, 2018: Wednesdays 10.00am – 11.30am
- Term 1, 2018: Wednesdays 1:00pm – 2:30pm
- Term 2, 2018: Wednesdays 10.00am – 11.30am
- Term 2, 2018: Wednesdays 1:00pm – 2:30pm

Please forward this referral form to:

Mail: Kids Are Kids! PO Box 1096 Booragoon WA 6954

Fax: (08) 9313 5566

Email: info@kidsarekids.org.au

Referrer details (if relevant)

Name: _____

Psychologist Psychiatrist Paediatrician Health Nurse Speech Pathologist OT Other

Organisation: _____

Best Contact: _____

Thank you for referring your client to the Cos Parenting Program for parents of children with additional needs.