

**Circle of Security Group Program:  
For parents of children with additional needs  
Referral/Registration Form**

**Child's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Parent/Carer Attending:** \_\_\_\_\_

**Address:**

Street \_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

**Home telephone:** \_\_\_\_\_ **Mobile telephone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Child diagnoses and presenting concerns:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relevant parental history/information**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- Term 4, 2018: Wednesdays 10.00am – 11.45am  
 Put on waitlist for future intake

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](mailto:info@kidsarekids.org.au)

**Referrer details**

Name: \_\_\_\_\_

Psychologist  Psychiatrist  Pediatrician  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.**