

C.L.A.S.S- Referral Form - Early Years/ Portage

Name of child	
Date of Birth	
Parents/Guardians Names	
Address	
Name and Address of Early years Setting if applicable	
Telephone Number	
Contact Person	
Educational Psychologist	
Medical Consultant	
Speech & Language Therapist	
Any other Professional Involvement <i>Please give name and title</i>	
Medical Diagnosis	
Any other relevant medical history	
Areas of Concern	
<p>I give permission for a referral to be made to CLASS for my child</p> <p>Signed: (Parent /Carer)</p> <p>Date:</p>	

Please return to Marilyn Brown at address below:-

Communication Language and Autistic Spectrum Support (C.L.A.S.S.) - ASD Resource Base
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