CEREBRAL PALSY ALLIANCE SINGAPORE

Cerebral Palsy Centre, 65 Pasir Ris Drive 1, Singapore 519529
Tel: 6585-5600 Fax: 6585-5603

Sensory Integration (SI) Clinic Referral Form

To: Sensory Integration Clinic **Date of referral**: _____

Name of Client: _____ **Date of Birth/sex** _____

Diagnosis: _____

Parents contact (HP No.) _____

Type of Program enrolled: □ Schooler □ EIPIC □ Out-Patient

Client is currently receiving services from:

- Speech Language Therapist Name/Organisation _____
- Occupational Therapist Name/Organisation _____
- Physiotherapist Name/ Organisation _____

Reason for Referral:

(Please briefly describe client's sensory issues that affecting his/her daily activities)

_____

_____

_____

Referred by:_____ (**Teacher/ EIPIC Interventionist/Parents/SLP/OT/PT**)
(Please, circle whichever appropriate)

Signature of referring staff: _____

Contact no: _____