APPLICATION FORM
EVALUATION

Applicant:

Surname ______________ First Name ______________ Initials ______________
Birthdate ______________ ID No ______________ Age ______________
Gender ______________ Ethnic Grp ______________ Home Language ______________
E-Mail ______________ Tel(H) ______________ Cellphone ______________
Drivers License (Y/N) ______________

Siblings:

Name: ______________ Gender: ______________ Age: ________ On spectrum? ________
______________ ______________ ________ ________
______________ ______________ ________ ________

Residential Address:

____
____
____
____
Postal Cd ______________

Postal Address:

____
____
____
____
Postal Cd ______________

Contact Person / Parent:

Surname ______________ First Name ______________ Relation ______________
Tel(H) ______________ Tel(W) ______________ Cellphone ______________
E-Mail ______________

Residential Address:

____
____
____
____
Postal Cd ______________

Postal Address:

____
____
____
____
Postal Cd ______________

Medical History:

At what age were you formally diagnosed: ______________ By whom: ______________
Dr's specialist field: ______________
Do you have a recent medical report available? ________ How regularly do you see the specialist? ______________
What chronic medicines do you currently use: ______________
____
Any additional medical conditions: ______________
____

List all known allergies:

____
____

Additional physical conditions (e.g. heart condition):

____
____

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Challenges:

	Severity:
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

PLEASE PROVIDE THE FOLLOWING INFORMATION:

1 Communication abilities:

2 Social interactions/abilities:

3 Perception of space:

4 Stimming habits:

5 Food preferences and dislikes:

6 Sleeping routine and habits:

7 Bathroom behaviours:

8 Family structure / support system:

____
____
____
____

9 Possible working history:

____
____
____
____

10 Reason for termination of employment, where applicable:

____
____
____
____

11 Hobbies and interests:

____
____
____
____

12 Any sports / physical activities:

____
____
____
____

13 Level of dependency on parents (1 – 10) (1 = Seriously dependent, 10 = totally independent): ____________

14 Additional information:

____
____
____
____
____

<u>Please attach a copy of the following documents:</u>

- ID Document
- Latest IEP/ISP/IVP (as applicable)
- Latest Specialist Report (from current specialist)
- List of current Chronic Medication (including any supplements)

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Signed at ___________________________ on _______th day of ___________________________ 20______.

Name ______________________________ Signature ____

Thank you for your application and the information provided. We will be in contact soon.

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