

# Edward Joyce

Educational Psychologist

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## Referral Form for a Psychological Assessment Private, confidential, and without prejudice

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Parent(s) or Guardian(s): \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

School: \_\_\_\_\_ Class/Year: \_\_\_\_\_

Address: \_\_\_\_\_ Roll Number \_\_\_\_\_

Name of Principal: \_\_\_\_\_ School Telephone No. \_\_\_\_\_

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**This section should be completed by the parent(s) or guardian(s)**

Family size: \_\_\_\_\_ Boys \_\_\_\_\_ Girls \_\_\_\_\_ Position in family \_\_\_\_\_

Has your child attended preschool? \_\_\_\_\_ Name \_\_\_\_\_

Any other National School Attended \_\_\_\_\_

If he/she has, please give details \_\_\_\_\_

Has your child repeated any class? \_\_\_\_\_

If he/she did, please give details: \_\_\_\_\_

Have you had any concerns about your child's early development (e.g. walking, talking)? \_\_\_\_\_

\_\_\_\_\_

**What are your main concerns (If any) about your child having this assessment?**

**If you have concerns, please give details.** \_\_\_\_\_

\_\_\_\_\_

**What are your child's special talents/abilities?** \_\_\_\_\_

\_\_\_\_\_

—

\_\_\_\_\_

**Has your child been assessed by any of the following?**

**Psychologist \_\_\_\_\_ Physiotherapist \_\_\_\_\_ Occupational Therapist \_\_\_\_\_**

**Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_**

**Outcome: \_\_\_\_\_ Outcome: \_\_\_\_\_ Outcome: \_\_\_\_\_**

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

**Speech and Language Therapist: \_\_\_\_\_ Paediatrician \_\_\_\_\_**

**Date: \_\_\_\_\_ Date: \_\_\_\_\_**

**Outcome: \_\_\_\_\_ Outcome: \_\_\_\_\_**

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

**N.B. Please enclose copies of any reports you may have received from the above.**

**Did your child have a hearing test? \_\_\_\_\_**

**Outcome: \_\_\_\_\_**

**Did your child have a sight test? \_\_\_\_\_**

**Outcome: \_\_\_\_\_**

**Does your child have difficulties with any of the following? (Please answer “Yes” or “No”)**

**Dressing/undressing \_\_\_\_\_ Tying shoelaces \_\_\_\_\_ Closing buttons \_\_\_\_\_**

**Managing cutlery \_\_\_\_\_ Hopping/jumping/skipping \_\_\_\_\_**

**Using playground equipment \_\_\_\_\_ Riding a bicycle \_\_\_\_\_ Using a**

**scissors \_\_\_\_\_ Standing on one leg \_\_\_\_\_ Walking on walls \_\_\_\_\_ Using a scissors**

**or pencil \_\_\_\_\_**

**Does your child have difficulty with any of the following? ( Please answer “yes” or “no” to the questions below)**

**Have difficulty making friends \_\_\_\_\_ Playing with children his/her own**

**age \_\_\_\_\_ Seem unaware of the rules of social conduct \_\_\_\_\_ Avoid taking part**

**in team games \_\_\_\_\_ Get agitated in crowded places, such as shopping centres**

\_\_\_\_\_ Seem reluctant to use playground equipment \_\_\_\_ Misinterpret what is said to him/her \_\_\_\_\_ Use formal, adult like language \_\_\_\_\_ Get irritated by certain clothing textures \_\_\_\_\_

Sometimes speak with an unusual accent \_\_\_\_\_ Become upset when routines or plans are changed \_\_\_\_\_ Have elaborate routines \_\_\_\_\_ If he/she does, please give details \_\_\_\_\_

Any other information you think may be relevant \_\_\_\_\_

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

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**This section should be completed by the class teacher and the learning support/resource teacher(s), where appropriate**

**What is the main reason for this referral ?**

Learning \_\_\_\_\_ Behaviour \_\_\_\_\_ Emotional \_\_\_\_\_ Other \_\_\_\_\_

Please give Details: \_\_\_\_\_

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

**\_ Is the child receiving: Learning Support ? \_\_\_\_ Resource teaching Support? \_\_\_\_**

**If he/she is/has, please answer the following:**

**Learning Support** \_\_\_\_\_ **Resource teaching support**  
**In what subject(s)?** \_\_\_\_\_ **In what subject(s)/area(s)** \_\_\_\_\_

**How often weekly?** \_\_\_\_\_

**Duration of classes?** \_\_\_\_\_ **How often weekly?** \_\_\_\_\_

**Please include the results of Standardised tests done in the last 2 years.**

Date	Name of test	Results- give S.S. and percentile rank

Please comment on the following, and if necessary elaborate further on page 5

<b>Attention/Listening</b>	
<b>Memory</b>	
<b>Concentration</b>	
<b>Oral skills</b>	
<b>Reading-Sight vocabulary</b>	
<b>Reading- Word attack skills-phonics</b>	
<b>Reading- Comprehension</b>	
<b>Mathematics- Computational skills</b>	
<b>Mathematics- Problem solving</b>	
<b>Spelling</b>	
<b>Writing skills</b>	
<b>Fine motor skills</b>	
<b>Gross motor skills</b>	
<b>Social skills with teachers/other adults</b>	
<b>Social skills with others his/her age</b>	
<b>Behaviour in class</b>	
<b>Behaviour in playground</b>	





**Consent Form**

**I/ We consent to a psychological evaluation of my/our son/daughter by Edward Joyce, Psychologist.**

**I/We understand that the results of this evaluation will be made known to me/us, to the School Principal, and, where the parents and Principal deem it appropriate, to the relevant members of the school staff.**

**Name of Student:** \_\_\_\_\_

**Signatures of both Parents or Legal Guardians: All persons who have legal custody of the child must sign this section.**

**Father:** \_\_\_\_\_ **Mother:** \_\_\_\_\_

**Legal Guardian:** \_\_\_\_\_ **Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Signature(s) of teachers completing this form:**

**Principal:** \_\_\_\_\_

**Learning Support teacher (s) /Resource Teacher(s):** \_\_\_\_\_

\_\_\_\_\_

**Date:** \_\_\_\_\_

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**N.B. Please enclose copies of reports received from other professionals/agencies**

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