TAKWEEN
Palestinian Center of Excellence
for Brain Development

Date of referral: _____

REFERRING PROVIDER

Referring Physician/Care giver: _____

Physician/care giver specialty: _____ **Phone #:** _____

Referring Facility/Organization: _____

Facility Phone #: _____

Patient Information			
Patient Name:			
Date of Birth:		Gender:	
Contact Person for Clinical Information:		Address:	
Contact person Home #:		Contact person Mobile #:	

Patient Medical Information

Cause of referral: _____

Suspected diagnosis: _____

Takween Center Building
Opposite Ministry of Finance
Al Masayef, Al Irsal Street, Ramallah

Tel. +970 2 295 4115
Fax. +970 2 295 4155
info@takweencenter.ps

www.takweencenter.ps

Suspected diagnosis: _____

_____

_____

Any current medical issues: _____

_____

_____

Needed services:

- ○ Neuropediatric Clinic
- ○ Cerebral Palsy Clinic
- ○ Vision rehabilitation Optometry Clinic
- ○ Clinical Psychology
- ○ Behavioral Therapy
- ○ Occupational Therapy
- ○ Speech Therapy
- ○ Physiotherapy
- ○ Hydrotheray
- ○ Special Education Clinic
- ○ Music therapy
- ○ Art therapy
- ○ Therapeutic Preschool

Signature: _____ **Date:** _____

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