

Specialist Children’s Services

Autism Assessment Service

**Autism Assessment Service Referral Form**

Please complete in as much detail as possible**.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child/Young person's (CYP) Name: | | | | DoB: | | | | | NHS No: | | | | |
| Address : |  | | | | | | | | | | | Postcode: | |
|  | | | | | | | | | | | | | |
| Carer’s name: (primary contact) | |  | | | | | | | | | | | |
| Address:  (if different) | |  | | | | | | | | | | | |
| Tel no: | |  | | | | Mobile: | | | | | | | |
| Preferred email: **(Essential)** | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Carer’s name:  (alternative contact) | |  | | | | | | | | | | | |
| Address:  (if different) | |  | | | | | | | | | | | |
| Tel no: | |  | | | | Mobile: | | | | | | | |
|  | | | | | | | | | | | | | |
| Who has parental responsibility (PR)? |  | | | | | Has a parent/carer with PR consented to referral?  Yes/No | | | | | | | |
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| Is the CYP Gillick competent to consent to ASD assessment? | | | | | Yes/No | | | Has the CYP consented to this referral? | | | | | Yes/No |
|  | | | | | | | | | | | | | |
| **Developmental History:** | | | | | | | | | | | | | |
| **Please summarise the CYP’s medical and developmental history including:** | | | | | **As reported by parent(s)/ carer(s):** | | | | | | **From other sources: e.g. your observation, Education or CAMHS** | | |
| Any significant illness or diagnoses? | | | | |  | | | | | |  | | |
| Is the CYP on any medication? | | | | |  | | | | | |  | | |
| Age at which early milestones were achieved: | | | | | Independent  Sitting:  Independent  Walking:    First words:  Phrase speech: | | | | | | Independent  Sitting:  Independent  Walking:  First words:  Phrase speech: | | |
| Any developmental concerns: | | | | |  | | | | | |  | | |
| Current academic attainment: | | | | |  | | | | | |  | | |
|  | | | | | | | | | | | | | |
| **Family history** | | | | | | | | | | | | | |
| Who does the CYP live with? | | | | | | | | | | | | | |
| Any known family medical history? | | | | | | | Yes/No | | | | | | |
| If Yes, please give details: | | | | | | | | | | | | | |
| Any known family history of mental health problems? | | | | | | | Yes/No | | | | | | |
| If Yes, please give details: | | | | | | | | | | | | | |
| Any family members with a diagnosis of ASD? | | | | | | | Yes/No | | | | | | |
| If Yes, please state who: | | | | | | | | | | | | | |
| Is the child or young person under the care of the local authority e.g. fostered? | | | | | | | Yes/No | | | | | | |
| Is the child or young person adopted? | | | | | | | Yes/No | | | | | | |
| Significant family history including parental separation, domestic violence, bereavement, new baby, prolonged time away from school, etc: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Please describe the CYP's difficulties in relation to:** | | | | | | | | | | | | | |
| **Area of difficulty** | | | **As described by parents:** | | | | | | | **As observed in clinic:** | | | |
| **Social Interaction e.g.**  Is eye contact used to regulate interaction?  Are there difficulties with friendships?  Are they able to understand how others feel? | | |  | | | | | | |  | | | |
| **Social Communication e.g.**  Can they maintain a two-way conversation on a variety of topics?  Do they have phrases that they repeat?  Do they use gestures when talking?  Can they be creative or use imagination? | | |  | | | | | | |  | | | |
| **Rigid and repetitive behaviours**  Do they have any unusual/intense interests?  Can they tolerate unexpected changes to normal routine?  Do they show behaviours that appear compulsive in nature?  Do they show any unusual mannerisms or sensory preferences? | | |  | | | | | | |  | | | |
|  | | |  | | | | | | |  | | | |
| **Other Professionals involved**: | | | | | | | | | | | | | |
| Is the family known to Social Services? | | | | | | | Yes/No | | | | | | |
| Name and Contact details of Social Worker: | | | | | | | | | | | | | |
| Is the CYP under the care of CAMHS? | | | | | | | Yes/No | | | | | | |
| Name and contact details of professional | | | | | | | | | | | | | |
| Other Professionals Involved with CYP/ family: | | | | | | | | | | | | | |
| Who? | | | | | | | Contact Details: | | | | | | |
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| **Name of referrer and designation:** | | | | | | | **Date of referral:** | | | | | | |
| Contact details of referrer including:  Phone no:  Email: | | | | | | | | | | | | | |

**Please return to: hdft.autism@nhs.net**