

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 |
|  |
| 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:  | IndependentSitting: Independent Walking: First words:Phrase speech: | IndependentSitting: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: |
|  |  |
|  |  |
|  |  |
|  |  |
| **Name of referrer and designation:** | **Date of referral:** |
| Contact details of referrer including:Phone no: Email: |

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