**Referral form for Children and Young People (CYP) AUTISM ASSESSMENT SERVICE**

**Scarborough, Ryedale and Whitby localities**

**Please note service commissioned to complete Autism Diagnostic Assessments only at this time.**

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| This form should be completed by the **professional** requesting the assessment. Please note that **ALL** sections must be completed. An incomplete referral form may result in a delay in the referral being accepted. |

**Prior to completing this form please make sure the referred person meets the following criteria:**

* **Person is school age (Reception class and up) and not over 18 years** at the time of the referral.
* **Person is not at risk to self -** being sufficiently stable to keep himself/herself safe throughout assessment, i.e. is not engaging in significant self-harm or attempts on own life.If person engages in significant self-harm or attempts on own life, acceptance of referral will only be considered if person has engaged with regular support and monitoring from local Child and Adolescent Mental Health team.
* **Person is not at risk of harming others** such that the assessor or other people accessing the service will be safe from physical attack.
* **Person’s BMI** is above18.
* **Person’s IQ is more than 70** meaning that he/she does not have a moderate or severe learning disability.
* **Person’s substances and/or alcohol** use is not at a level that may interfere with observational assessments/ability to engage in assessment process.
* **Person and family/carers have given fully informed consent** as indicated on the referral form.
* **Person shows clear difficulties in all areas that form the Autism Spectrum: (i) social communication, friendships and relationships; (ii) repetitive behaviour, resistance to change; (iii) highly specific interests; (iv) sensory issues.**
* **Please update us if there any significant changes in the young person’s presentation or care**

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| **CHILD OR YOUNG PERSON’S DETAILS** | | |
| **Full name:** | | Address: |
| **Name preferred to be called, if different from full name:** | |
| **\*Date of birth:** | |  |
| **\*NHS number:** | | Postcode: |
| **Identified sex:**  Female  Male  Other………………  *(please circle or specify)* | **Gender the child or young person identifies with:**  Girl/woman  Boy/man  Transgender  Other or prefer not to disclose  *(please circle or specify)* | Mobile:  Home:  Email:  (Your email will not be shared with anyone. This would be a particular useful means of contact during the COVID-19 pandemic )  **Please state preferred method of communication:** |
| Language(s) spoken and understood *(include sign language if relevant)*  ***Please tick here if an interpreter is required.*** | | |

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| **PARENT/CARERS’ DETAILS** | | | |
| **Parent/Carer full name and relationship to person referred** | | | |
| **Parent/Carer address and contact details (if different to the above)** | | | |
| **Name and address of ALL Parents/Carers with legal parental responsibility (if different from above)** | | | |
| Has the person with legal responsibility for the child or young person consented to this referral? | Yes | No | Don’t know |

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| **REASON FOR REFERRAL -** *Please explain why you are making this referral. The sections below are areas that we require information to decide if an autism assessment is needed. We have added* ***examples*** *that you might expect to see in a child that should be referred for an autism assessment. Please put a cross in the box next to any examples that apply, and add any additional information that family/carer is giving. Some information required in each of sub-sections 1 – 8:*  *Please fill in each section indicating difficulties, if no difficulties please add this to the section that states “other”* | | | | | |
| 1. Language and communication skills | | | | | |
| *Difficulties with language* |  | *Talks ‘at’ people and little two-way conversations despite good verbal language skills* | | |  |
| *Engages in little verbal communication* |  | *Struggles to make eye contact or read facial or expressions or to show facial expressions* | | |  |
| *Repeats spoken language back verbatim* |  | *No social chat, preference for talking about own specific interests* | | |  |
| *Takes language literally* |  | *No difficulties in this area* | | | |
| *Other (please state)* |  |  | | | |
| 1. Social interaction skills with others | | | | | |
| *Difficulties with making and keeping friends* |  | *Tends to hang back and observe other children but struggling to approach peers* | | |  |
| *Prefers being around adults* |  | *Shows interest in other children but doesn’t seem to know how to approach* | | |  |
| *Takes little interest in other children* |  | *Consistently approaches other children in a way that results in conflict/trouble* | | |  |
| *No difficulties in this area* |  |  | | |  |
| *Other (please state)* | | | | | |
| 1. Interests and play skills | | | | | |
| *Shows little imaginative play* |  | *Struggles to engage in joint play* | | |  |
| *Tends to play on own* |  | *Dominates in play interactions (e.g. always needing to be in charge)* | | |  |
| *Joint play (with peers or carers) frequently results in conflict* |  | *No difficulties in this area* | | | |
| *Other (please state)* |  |  | | | |
| 1. Repetitive behaviour (motor, vocal or in their play/interests) | | | | | |
| *Shows repetitive movement (flapping hands, spinning body repetitively, rocking body) or repetitive verbal utterances (repeating same phrases, sounds)* |  | *Has highly specific interests that pursues to an extreme extent (including collecting information on particular topics)* | | |  |
| *Engages in repetitive play (lining up toys, replaying same actions over and over)* |  | *Insists on certain routines (same cutlery/food items, any aspects of environment having to be certain way)* | | |  |
| *No difficulties in this area* |  |  | | |  |
| *Other (please state)* | | | | | |
| 1. Ability to cope with change and transitions | | | | | |
| *Difficulties with transitioning between activities/settings – or requiring a lot of preparation and support from family/teachers/carers* |  | *Struggles to cope with unexpected changes/events* | | |  |
| *No difficulties in this area* |  |  | | |  |
| *Other (please state)* | | | | | |
| 1. Sensory issues (over- or under-responsive to sounds, touch, etc) | | | | | |
| *Responds with distress to auditory/visual stimuli* |  | *Dislikes being touched or has preference for tight hugs* | | |  |
| *Appears distressed in busy environments* |  | *Strong response to any stimuli (or lack of response)* | | |  |
| *No difficulties in this area* |  |  | | |  |
| *Other (please state)* | | | | | |
| 1. Self-help skills and independence | | | | | |
| *Lack of independence in self-care* |  | *Difficulties with getting dressed/feeding* | | |  |
| *No difficulties in this area* |  |  | | |  |
| *Other (please state)* | | | | | |
| 1. Behaviour (including any that is causing concern) | | | | | |
| *Experiences periods of ‘meltdowns’, becoming overstimulated and shutting down* |  | *Extreme anxiety in social situations or new environments* | | |  |
| *No difficulties in this area* |  |  | | |  |
| *Other (please state)* | | | | | |
| Please list any diagnoses that have already been used to describe the child or young person’s difficulties and *provide the date these were given if possible*: | | | | | |
| Are there any concerns about the child or young person’s mobility (including clumsiness)? Please give details: | | | | | |
| Are there any concerns about the child or young person’s vision or hearing? Please give details: | | | | | |
| Is the child or young person on any medication? *If yes please specify and reasons for taking*  ***\*Does the child take Melatonin?*** *Yes No* | | | | | |
| Does the child have any Learning needs? (e.g. require additional help at school for academic work) Please give details: | | | | | |
| Do they have an Education and Health Care Plan (EHCP)? *If yes when was it issued?* | | | | | |
| **Young person’s views about this assessment:** *Where appropriate, it is our expectation that all the information contained within the form is known to the young person you are referring.* | | | | | |
| Have you discussed this referral with the CYP and have they agreed to it? | | | Yes | No | |
| What are the views (if any) of the young person about this referral? | | | | | |
| **Please use this box to make us aware of any other information which you feel is important for our team to be aware of:** | | | | | |

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| ***HEALTH:*** *please detail any concerns about the child’s health and well-being (including mental health)* ***Please forward any reports or additional information that is relevant to this referral.*** | ***GP DETAILS*** |
| ***\*Please tick box to confirm BMI is greater than 18*** | Name |
| Address |
| Tel no |
| ***MENTAL HEALTH:*** *Please detail any current or historical concerns about the child’s mental health. (Risk, self-harm, suicidal ideation ect.)* | ***SAFEGUARDING:*** *Please detail any current or historical safeguarding concerns (e.g. involvement from Social Care or the Early Help Hubs).* |
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| **PROFESSIONALS CURRENTLY INVOLVED** | | | | | |
| Health Visitor |  | Occupational Therapist |  | Social Worker |  |
| Paediatrician |  | Physiotherapist |  | Educational Psychologist |  |
| Clinical Psychologist |  | Psychiatrist |  | Speech & Language Therapist |  |
| CAMHS worker |  | Others, please list |  |  |  |
| **Please give details of any professionals who have PREVIOUSLY been involved** | | | | | |
| **SPECIAL REQUIREMENTS: e.g. Wheelchair Access etc. Please give details below:** | | | | | |
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| ***SCHOOL:*** *Please detail any concerns about education, (including additional support provided)* | ***SCHOOL DETAILS***  ***Please be aware information from the school is relevant for our team to be able to process this referral*** |
|  | Contact Name |
| Address |
| Tel no |

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| **REFERRER DETAILS:** | | | |
| I have discussed the autism assessment pathway with the child/young person and family/carer(s) and they agree to be referred to the Children and Young People’s Service at The Retreat York. | | | |
| Name: |  | Job Title: |  |
| Organisation Name: |  | Tel. No: |  |
| Address: |  | Mob. No: |  |
| Postcode: |  | Email: |  |
| Referrer’s Signature: |  | Date: |  |

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| **PARENT/CARER CONSENT:** *(The parent must have parental responsibility to sign for this)* | | | | |
| I give consent for my child/young person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_to be referred for an assessment.  YES NO | | | | |
| Printed Name: | |  | Signature: |  |
| Date: | |  |
| **RETURNING THE FORM:** | | | | |
| Please note that all sections must be completed. An incomplete referral form may result in a delay in the child being seen. All completed forms must be returned to:  Children and Young People Neurodevelopmental Services  The Retreat at Charles Court  Northfields, Strensall, York YO32 5XP  Tel. No: 01904 412 551 option 3 Email: [nyccg.retreatautism@nhs.net](mailto:nyccg.retreatautism@nhs.net) | | | | |
| **PRIVACY STATEMENT** | | | | |
| For the purposes of this form, The Retreat is the data controller responsible for the processing, storage and use of the data. If you have queries relating to how your data is handled then please contact the relevant Administration Lead. Further details about how we handle your data, including the contact details of our Data Protection Officer, can be found in our Privacy Notice at: <https://www.theretreatyork.org.uk/> | | | | |
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