

**Autism Spectrum Assessment**

**Referral Form**

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| **Guidance: Please read prior to completing the referral form*** Autism is a lifelong neurodevelopmental condition which has a significant and pervasive impact on a person’s social functioning.
* If you do not think concerns are sufficient at this time to prompt a referral, consider a period of ‘watchful waiting’ or contact the service to discuss concerns prior to referring.
* It is important that a referring professional has discussed the implications of a diagnosis with the family and the child/young person (if appropriate). Is this the right time for referral?
* Any referring professional must have observed the child before a referral can be made by them
* **Please ensure that the consent to refer is explained to the parent / carer / young person giving consent for assessment and is read and understood before they sign it.**
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| **Child/Young Person’s Details** |
| **Name:** | **Date of birth:** |
| **Address:**  | **Telephone number:****Home:** **Mobile:** |
| **NHS Number:** | **Is the child/young person Looked After? YES/NO** |
| **Ethnicity:**  | **Spoken language:****Is an interpreter needed?** Yes / No |
| **GP name and address:**  | **GP Telephone number:**  |
| **Referrer Details**  |
| **Name:** **Contact number:****Contact email:** | **Contact address:****Signature:** **Date of referral:** |
| **Consent to Refer**  |
| **Please discuss the process with the child/young person. Where they are able to decide for themselves whether the assessment should go ahead (or not), please ensure they are happy to proceed and (if they agree) please request their written consent below.*** **Where Parent/Carer is consenting on child’s behalf**

What does the child understand about this assessment? (Please show relevant information)Have they any worries or concerns regarding the process? * **Where Child/Young Person is consenting for themselves**

Do you feel you understand the autism assessment process? Have you any worries about what will happen? To be completed by Parent/Carer or Child/Young Person ***[please read carefully and******delete sections in bold* *as appropriate*]** I give my permission for **[my child / myself]** to be referred for an Autism Assessment which may include a referral to any of the following professionals: Speech and Language Therapist, Educational Psychologist, Clinical Psychologist and Paediatrician. I have been informed of the purpose of these referrals and understand what it involves. I understand that a referral does not guarantee an assessment will be completed but it will be considered by Autism Assessment Team. I agree that the Team may seek and store information from other professionals (including medical or other health specialists) who are or may become involved to assist in assessment. I also give permission for the Team to share/request relevant information and opinions about **[my child / myself]** with professionals involved. This could include Community Paediatricians, Speech and Language Therapists, Education Psychologists, Clinical Psychologists and others as appropriate. I also give consent to receive correspondence via digital means (including SMS and email).I understand that I can withdraw this consent at any time by informing the referrer above or by contacting the Autism Assessment Team. I understand that information will be retained for as long as is necessary to determine the appropriate course of action and that records will be maintained in line with the Humber NHS Teaching Foundation Trust Records Management Policy.**Name of Parent/Carer or Child/Young Person (please write clearly)****Relationship to child (if required)****Signature consenting to referral****Date**  |
| **Information about the Child/Young Person** |
| **Additional diagnoses** (e.g. ADHD, epilepsy, motor disorders, intellectual disability, complex language disorders or complex mental health disorders - please attach reports if available) |
| **Do they have a physical, hearing, or visual impairment? YES/NO***If ‘YES’, please provide details:*  |
| **Does the child/young person take any medication? YES/NO***If ‘YES’, please provide details.*  |
| **School/college attended:** **Contact details:****Do staff have any current, significant concerns?** YES / NO If yes, please provide details: |
| **Are any other agencies involved with the child/young person?** (Please provide contact details and attach reports if relevant). |

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| ***Factors to consider (REF: NICE Guidelines, 2011, 1.3.3)*** |
| **Is the child / young person older than three years with a regression in language?***(if yes, refer to community paediatrician)* | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| **Does the child / young person (of any age) have a regression in motor skills?***(if yes, refer to community paediatrician)* | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| A sibling diagnosis of autism  | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Birth defects associated with central nervous system malformation and/or dysfunction, including cerebral palsy | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Gestational age less than 35 weeks | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Parental schizophrenia-like psychosis or affective disorder  | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Maternal use of sodium valproate in pregnancy | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Intellectual disability | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Neonatal encephalopathy or epileptic encephalopathy, including infantile spasms  | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Chromosomal disorders such as Down's syndrome | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Genetic disorders such as fragile X | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Muscular dystrophy | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Neurofibromatosis | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |
| Tuberous sclerosis | **YES**  |
| **NO** |
| **UNABLE TO COMMENT** |

**Autism Indicators** |
| **If you are able, please answer the following questions:****Comments:** |
| **Developmental History (brief)** |
| **Significant antenatal information** (e.g. Pregnancy/maternal substance use/trauma):**Birth difficulties** (e.g. Complications/trauma/mental health difficulties):**Speech and language development** (e.g. When did the child/young person first use single words? When did they first use phrase speech? Did the child/young person’s speech regress at any time? If so, when/how?)**Motor milestones** (e.g. Did the child /young person’s meet their motor milestones as expected? Was there ever a regression in skills observed?)**Toileting** (e.g. Were there any significant delays in acquiring day time and night time continence?) |
| **Child/Young Person’s Views**  |
| What makes them happy in their life at the moment?Who is important to them? What are they good at?What do they think could be better in their life at the moment?What do they think they need more help with?What do they know and understand about this assessment? Have they any worries or concerns? Have they been shown the Panel leaflets to help them understand a bit more?  |
| **Thank you for completing this form.** |

Please return complete forms to email: hnf-tr.hullandeastridingneurodiversityservice@nhs.net

**OR**

Neurodevelopment Team

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