

**Referral Form**:

**Autism Diagnostic Services**

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| Referring Agency:Parent, GP, Consultant, Local Authority etc. | Referral for child or young person: |
| Name |  | Name |  |
| Address |  | DOB |  |
| Address |  | NHS number |  |
| Post Code |  | ID number |  |
| Telephone |  | Is this referral for a child looked after? Yes [ ]  No [ ]  |
| Email |  |  |
| Date |  |  |
| Parent/Carer |  |
| Name |  | Please tell us if you have any needs in terms of language or mobility. |
| Address |  |  |
| Address |  |  |
| Post Code |  |  |
| Telephone |  |  |
| Email |  |  |
| Reason for referral |
| **Social relationships and friendships** *What kind of friendship circle they have? What kind of people they get on with more often? Do they prefer to play with peers or younger and older children?* |  |
| **Following instructions and paying attention***Do they understand what they are asked to do? Do you have to repeat it or break it down for them?* |  |
| **Communication***Do they use words, full sentences, phrases or are non-verbal? How sophisticated is their vocabulary?* |  |
| **Behaviour** *How do they cope with disappointments, sadness, feeling hurt, being told no, having to wait? Do they hurt themselves when feeling angry or overwhelmed? Do they do self-harm such as cutting their arms or other parts of their body?* |  |
| **Sensitivity to noise and environments** W*hat’s it like to take them to noisy and busy places? Do they avoid certain places and why is that?*  |  |
| **Very anxious about small changes in routines etc**. *How do they respond when you have to change things at the last minute?*  |  |
| Parental aims and desired outcome of referral |
| Who has parental responsibility? |  |
| Are parents in agreement with the referral? |  |
| Has the child or young person previously had an autism assessment? If yes, when and where did this take place and what was the outcome? |  |
| Any current diagnosis (learning disability, epilepsy, dyslexia, ADHD, depression etc.) |
|  |
| Current medication if applicable - please include name, strength and dose |
|  |
| Other services involved with child or young person |
| CAMHS Respite Social Services | [ ] [ ] [ ]  |  |
| Other professionals involved or previously seen: |
| Professional |  | Name and address | Consent to Contact |
| Paediatrician |[ ]   | Yes [ ]  No [ ]  |
| Psychiatrist |[ ]   | Yes [ ]  No [ ]  |
| Psychology |[ ]   | Yes [ ]  No [ ]  |
| OccupationalTherapy |[ ]   | Yes [ ]  No [ ]  |
| Speech and Language Therapy |[ ]   | Yes [ ]  No [ ]  |
| Other |[ ]   | Yes [ ]  No [ ]  |
| School provision – is the child or young person currently in full time education? If not please provide details. |
|  |
| Child or adult protection concerns. Have there been any pervious child or adult protection concerns that Young Epilepsy need to be aware of to support the child or young person effectively and manage risk? |
|  |
| Please provide below or attach any other relevant information you feel may be helpful in considering this referral such as any previous reports. |
|  |
| Please return the completed form and relevant information to: |
| Head of WellbeingYoung Epilepsy, Neville Centre, St Piers Lane, Lingfield, Surrey, RH7 6PWyoungepilepsy.healthservices@nhs.net 01342 832243 |