**Autism Spectrum Disorder Assessment Service (ASDAS)**

**Referral Form**

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| ***Instructions on using this form:*** 1. Please download and fill out the Community Paediatrics referral (SPA) form which can be found here <https://www.bartshealth.nhs.uk/referral-forms> 2. Please send ***both*** completed referral forms to: thgpcg.spa@nhs.net  For any queries, please contact the ASDAS Team on 0207 767 3322 (option 2) or email us at bartshealth.communityasdasteam@nhs.net |

**Please complete ALL sections and give examples of the behaviours you have seen.**

**Incomplete forms and missing information will delay your referral being processed.**

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| **Child / Young Person’s Details** |
| Child/ Young Person’s Name: | Date of Birth: | Gender: |
| Tel Number of Parent/carer: Email address: | If interpreter needed for parents which language: |
| Full Address:  | NHS No (*if known)*: |
| School/Education Provider: |  |

***Consider involving someone who knows the child well when completing this form***

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| **Details of Person/s completing/contributing to this referral form:** |
| **Date of referral made: DD/MM/YYYY** |
| **Referrer’s Name:** |  | **Telephone:** |  |
| **Job title/****Relationship to young person:** |  | **Email:** |  |

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| **Child / Young Person’s Strengths**  |
| **Tell us the things the child/young person is good at and what you like about them.**  | 1.  2.  3.   |

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| **Background / Social context** |
| Who **lives** at **home**? Languages spoken at home?Family history of social, mental health or communication needs?Since the C/YP was **born** have there been any **significant** **changes** in their **home** life?*e.g. moves, separations, losses, traumas, illness or injury (time may have felt very frightened / neglect / abuse / injury – history of hospital attendance)?*  |  |
| What current/ past **physical** **health** needs/ conditions does the C/YP have that you are aware of?*e.g. sleep, eating/drinking, dental, hearing, vision, bladder/bowel, mobility, genetic conditions/investigations, medications* |  |
| What support have the family accessed already with regards to your concerns? What services have you linked the family with? |  |
| Special considerations (E.g. risk issues, difficulties attending appointments, need for interpreter or other special adjustments) |  |

Please note that for a referral to be accepted:

* The child must be **2 years** or older.
* There must be in-depth information and specific examples e.g. *“they don’t like change”* **isn’t** enough information. Please explain **how** they respond to specific changes.
* Please avoid language such as *“they are obsessed with ...”* instead describe the **intensity** and **frequency** in terms of time and what C/YP is **doing**.
* Think about phrases like “*they don’t like loud noises*” or “*they prefer routine*” - this could be true of most people. **What is unusual** about what you have observed?
* We must see clear differences in all sections of the referral form (social communication and interaction, interests and behaviours, sensory, learning and development, **and** the impact of these differences on every day life).

**Without sufficient information, the referral will be rejected.**

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| **Social Interaction and Communication**  |
| Describe and give examples of **how** the child/young person **communicates** **with** **you and others**.  *How do they get your attention, share what they like, ask for help, can they tell you what has happened, style of speech/tone of voice?* |  |
| Describe and give examples of child/young person’s **understanding of language***Can they follow instructions, comprehension of stories, processing time, non-literal language, share and understand jokes?* |  |
| Describe and give examples of child young/person’s **use and understanding of nonverbal communication***Facial expressions, gesture, eye-contact* |  |
| Describe and give examples of child/young person’s **recognition and expression of their emotions***Describe a wide range of emotions e.g. happy, sad, angry, anxious, embarrassed, scared, guilty* |  |
| Describe and give examples of how the child/young person **interacts with you and others.***Friendships, approach and interest in others, differences in adults vs peers, strangers, their role in relationships* |  |
| Describe and give examples of the child/young person’s **perception of others.***Recognition of intentions, perspectives, emotions, jokes/banter* |  |
| Describe and give examples of any other differences in this area *Masking, practising interactions, sense of justice, imagination/fantasy*  |  |

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| **Interests** **and** **behaviours** |
| Describe and give examples of how the child/young person **plays** / spends their **leisure** **time**. Now or when younger.*Who do they play with?**What do they play with?**How do they play with it?*  |  |
| Describe and give examples of any **unusual** or **intense** **interests** the child/young person has. Now or when younger.*Describe the intensity and frequency.* *Why is it unusual? Are other people their age also interested in these things?* |  |
| Describe and give examples of how the child/young person **responds to change***Distress, rigidity, transitions, preparation for new places. How are changes typically managed?* |  |
| Describe and give examples of any other differences in this area |  |

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| **Sensory** |
| Please describe and give examples of any **sensory** **differences** the child/young person might have. Now or when younger.*Aversions, sensory seeking**Describe the intensity and frequency. Is this a preference or difference? How does it affect daily life?* |  |
| Please give any examples of **unusual or repetitive** **body** **movements** the child/young person does.  Now or when younger.*Tell us why you think it is unusual. What context do you notice these movements in?* |  |
| Describe and give examples of any other differences in this area |  |

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| **Learning / Development** |
| Please provide information about child’s/young person’s **general** **development**/**learning**.  *Is there an identified delay?* *Is it in line with their peers?* *Any areas of over achievement?* *How have they responded to support at school?* |   |
| Please describe the child’s **organisation** and **concentration** skills.*e.g. forgetting and losing things, fidgeting, problem solving strategies, easily distracted* |  |
| Please describe the child/young person’s **independence** **skills**. *e.g. need for supervision, feeding self, personal care, toileting, helping in class, asking for help, etc.* |   |
| SCERTS communication level (if established) | * Social Partner
* Language Partner
* Conversation Partner
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| **Impact** |
| How do all the difficulties you described **impact** the child/young person’s **wellbeing**? |  |
| How do all the difficulties you described **impact** the **child**/**young** **person’s** day to day life?  |  |
| How do all the difficulties you described **impact** the **family’s** day to day life?  |  |

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| **Parents/Carers/Young person** |
| **How** have you **explained** your Autism **concerns** to the Parents and/or young person.What is **their** **understanding as a result of your discussion?** *Neurodevelopmental condition (lifelong)**Learning difference* ***not*** *disability/illness* |   |

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| **Supporting Information**  |
| Please include with this form the following **desirable** information, where possible. Please ensure any relevant and key information is included in this referral form.  | * SLT report
* Educational Psychology report
* Relevant Medical reports
* Relevant EHCP pages or school report
* Other Professional reports – e.g. CAMHS, Audiology, Social Care, Behaviour Support,
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