SAMPLE

**Integrated Autism Service**

**Diagnostic Assessment Referral Form**

**Referrer Details**

|  |  |
| --- | --- |
| **Date** |  |
| **Name** |  |
| **Address** |  |
| **Telephone Numbers** |  |
| **Email address** |  |
| **Relationship to the referred person** |  |

**Details of Individual Referred**

|  |  |
| --- | --- |
| **Surname** |  |
| **Forenames** |  |
| **Gender (circle)** | Male Female |
| **Date of Birth** |  |
| **Current Address** |  |
| **Telephone numbers** |  |
| **Email address** |  |

**Carer Details (if relevant)**

|  |  |
| --- | --- |
| **Surname** |  |
| **Forenames** |  |
| **Address** |  |
| **Telephone numbers** |  |
| **Email address** |  |

**GP Details**

|  |  |
| --- | --- |
| **Name** |  |
| **Surgery Address** |  |
| **Telephone Number** |  |

**Please outline the SIGNS / Symptoms the individual is experiencing:**

**The examples below have been designed to help support your referral. For referral guidelines see NICE Guideline CG142: Autism in adults: diagnosis and management [Link:**[**http://www.nice.org.uk/guidance/cg142**](http://www.nice.org.uk/guidance/cg142)**] and Royal College of GPs Autism Spectrum Disorder Toolkit** [**http://www.rcgp.org.uk/clinical-and research/toolkits/asd-toolkit.aspx**](http://www.rcgp.org.uk/clinical-and%20research/toolkits/asd-toolkit.aspx) **or** www.ASDinfoWales.co.uk/recognise-ASD-adult

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| --- | --- | --- | --- | --- | --- | --- |
| **Social interaction and verbal communication**  Examples may include problems with use/understanding of language; lack of interest in social interaction; difficulty with social-communication, social relationships, friendships, awareness of/ response to others’ feelings | | | | | | |
| **Please detail the impact of difficulties (including areas of life impacted)** | | | | | | |
|  | | | | | | |
| Please circle if difficulties experienced with: | | | | | | |
| language (limited, repetitive, echoed (echolalia) or literal ) | Interaction with  age-peers (avoidant, passive or indifferent) | Approaches to others (one-sided, non-reciprocal) | Making or keeping friendships | Awareness of or response to others’ feelings | Comfort seeking or comfort giving | Sharing of interests/  enjoyment with others |

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| --- | --- | --- | --- |
| **Imagination, ideas and creativity**  Examples may include lack of pretend play with toys in childhood, solitary imaginary activities, lack of generating or sharing of creative ideas with others (all ages), ability in older children and adults to foresee consequences of own actions or expectations, intentions of others | | | |
| **Please detail the impact of difficulties (including areas of life impacted)** | | | |
|  | | | |
| Please circle if difficulties experienced with: | | | |
| Generating spontaneous creative, ideas | Sharing imaginative activities with others | Predicting others’ expectations, intentions | Imagining consequences of own actions on others |

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| --- | --- | --- | --- |
| **Gestures and non-verbal communication**  Examples may include: infrequent use of pointing to show objects, gestures that lack spontaneity, or appropriateness, particularly gestures expressing emotion; facial expression, tone of voice, eye contact, body language, proximity | | | |
| **Please detail the impact of these symptoms (including areas of life impacted)** | | | |
|  | | | |
| **Please circle if difficulties experienced with:** | | | |
| Pointing to show /share objects | Emotionally expressive gestures | Tone of voice, facial expression or eye-contact | Body language, proximity |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Narrow range of interests, routines and repetitive behaviours**  Examples can include limited pattern of self-chosen activities, arranging objects in patterns, repetitive motor behaviours (e.g. hand flapping, spinning) repetitive routines/rituals, over-focused interests | | | | |
| **Please detail the impact of these symptoms (including areas of life impacted)** | | | | |
| : | | | | |
| **Please circle if difficulties experienced with:** | | | | |
| Limited pattern of self-chosen activities | Arranges objects in patterns (may dislike their disturbance) | Insists on routines being unchanged | Repetitive motor behaviours | Over-focused interests |

|  |  |  |
| --- | --- | --- |
| **Sensory Responses**  Examples can include heightened sensitivity to or avoidance of particular sensations (sights, sounds, touch, smell, or taste; unusual seeking out of sensory sensations; reduced sensory reaction to pain or temperature | | |
| **Please detail the impact of these symptoms (including areas of life impacted)** | | |
|  | | |
| **Circle all that apply:** | | |
| Unusual responses to particular sounds, sights, | Unusual responses to taste, smell, touch | Reduced sensory reaction to pain or temperature |

**Has the person experienced any of the following?**

|  |
| --- |
| Please provide details of any problems in obtaining or sustaining education or employment: |
| Please provide details of any difficulties in initiating or sustaining social relationships: |
| Please provide details of any previous or current contact with mental health or learning disability services: |
| Please provide details of any history of neurodevelopmental condition or mental disorder: |
| Does the individual have family member with a diagnosis of ASD or other neurodevelopmental condition ?: |

**Additional Information**

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| --- |
|  |

**Please return to:**

**Or complete online via the IAS portal at:**

**Consent**

The Integrated Autism Service provides support in conjunction with a range of organisations to help autistic individuals (and adults who suspect they may be autistic and wish to be assessed).

I understand that by consenting to this referral I am agreeing to access support from the service and the organisations that work alongside it.

I understand that the information recorded will be used to help professionals understand what help I need and that it may be shared with other agencies as part of the process.

I understand that where I do not agree to sharing information with other agencies then this may affect the service provided and that I may not receive any service.

I understand the information that is recorded will be stored according to the Integrated Autism Service Information Sharing Protocol and used for the purposes of providing the support requested. I also understand that anonymised data will be shared with external partners for the purpose of monitoring and evaluation.

If you do not consent to this information being shared please do not sign the form. If you wish to share information with particular agencies only or not share information with agencies, please specify below.

**I understand the process and I consent to this information being shared**

**I understand the process and I consent to this information being shared with only the following agencies**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **Individual name** |  |
| **Individual signature** |  |
| **Date** |  |