**Please return completed forms to:**

**Building 1/Adeilad 1**

**St David’s Park/Parc Dewi Sant**

 **Job’s Well Road/Heol Ffynnon Job**

** Carmarthen/Caerfyrddin SA31 3HB**

**Tel: 01267 283070/283061**

**Email: westwalesias.hdd@wales.nhs.uk**

**REFERRAL FORM FOR ADULT ASD DIAGNOSIS AND TO THE WEST WALES INTEGRATED AUTISM SERVICE**

**SECTION 1**

**Service User’s Details**

|  |  |
| --- | --- |
| Forenames: | Surname: |
| Preferred Name: | Title: |
| Address: | Date of Birth: |
| NHS number: |
| Email address: | Phone number(s): |
| Preferred language: | Ethnicity: | Gender: |
| Do you or your parent/carer need an interpreter? Yes No(i.e the first language is not Welsh or English)If so, what language? |

**Parent/Carer Details (if relevant)**

|  |  |
| --- | --- |
| Name (carer 1): | Name (carer 2): |
| Relationship to service user: | Relationship to service user: |
| Address: | Address: |
| Email address: | Email address: |
| Phone number: | Phone number: |
| Preferred language: | Preferred language:  |

**Referrer Details**

|  |  |
| --- | --- |
| Name: | Date of referral: |
| Address: | Profession: |
| Email address: | Phone number: |

**GP Details (if not the referrer)**

|  |  |
| --- | --- |
| Name: | Address: |
| Phone number: | Email address: |

**Other Professionals Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Service | Contact details | Dates of involvement |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Please comment on any relevant issues relating to risk**

|  |
| --- |
|  |

**Previous or current contact with mental health or learning disability services**

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|  |

**Additional information including specific requirements when accessing services**

|  |
| --- |
| (E.g. difficulties with communication including reading and writing, hearing, mobility, transport) |

**Reason for referral**

**If referral is for Adult autism diagnostic assessment please complete SECTION 2**

**For all other referrals for support please complete SECTION 3**

Please note: for a diagnostic assessment for a child/young person under 18 years of age please make a referral to the Neurodevelopmental Service.

**SECTION 2 – Request for Adult Autism Diagnostic Assessment**

Please note: for a diagnostic assessment for a child/young person under 18 years of age please make a referral to the Neurodevelopmental Service.

**Developmental history**

|  |
| --- |
| (E.g. delays in meeting development milestones; loss of skills they had acquired; unusual behaviour in childhood; differences in interaction; additional educational needs; were they known to any health (e.g. paediatrician) or social care services when they were a child?) |

**Social interaction**

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| --- |
| (E.g. does the person have difficulties: making and/or maintaining relationships; understanding and managing their own emotions; understanding other people’s emotions; understanding social rules?) |

**Social communication**

|  |
| --- |
| (E.g. does the person have: difficulties with reciprocal communication; use of learnt phrases; repetitive use of language; unusual eye contact; reduced facial expression or gesturing; flat intonation; taking things literally?) |

**Repetitive/restrictive behaviours**

|  |
| --- |
| (E.g. does the person have highly focused all-encompassing interests; excessive adherences to routines that are unusual; resistance to change; inflexible thinking; repetitive behaviour or rituals; strong adherence to rules; repetitive or stereotyped movements?) |

**Sensory differences**

|  |
| --- |
| (Does the person seem to have significant sensory differences? E.g. not noticing pain; noticing sounds, smells, tastes or visual details that others do not; difficulties with food due to textures or taste sensitivities; avoiding touch; different temperature regulation) |

**Has the person had or are they currently having difficulties with obtaining or sustaining education or employment?**

|  |
| --- |
|  |

**Has the person had or are they currently having difficulties in initiating or sustaining social relationships?**

|  |
| --- |
|  |

**Does the person have any other diagnoses or history of medical or neurodevelopmental conditions?**

|  |
| --- |
| (E.g. learning disability, global developmental delay, attention deficit hyperactivity disorder (ADHD), mental health condition, stroke) |

**Permission**

|  |
| --- |
| **Please note, referrals will not be accepted without the permission of the service user you are referring.** **Please advise the client that the IAS are a multi-agency team so information may be accessed by both local authority and health staff who work in the IAS team.*****If the referral is for a diagnostic assessment please advise the client that the IAS will want to access previous medical notes around difficulties with childhood development, mental health and learning difficulties/disabilities. Please also advise the client that referrals for adult diagnostic assessment may be discussed with colleagues from other Health services to ensure the most appropriate assessment is undertaken.*****This referral will be discussed at our weekly referral meeting and the individual, GP and referrer (if different) will be notified by letter of the outcome.****Have you discussed this referral with the person? Yes No****Has the person given their permission for this referral to be made? Yes No** |

**SECTION 3 – Request for Support**

**Please note, clients referred for support must have a formal diagnosis or be the parent/carer of an individual with a formal diagnosis of ASD. Professionals seeking support should complete this section.**

**If the request is for a diagnostic assessment for an adult please complete SECTION 2.**

**Current Diagnosis (please tick)**

|  |  |
| --- | --- |
| **Autism Spectrum Disorder, Autism, Asperger Syndrome** | **No diagnosis****(Please make a referral for diagnostic assessment using section 2)** |
| **Other (please specify):** |

**Details of diagnosis (please attach a copy of the diagnostic outcome report/letter if possible)**

|  |
| --- |
| **Date/year the diagnosis was given:** |
| **Who or which service gave the diagnosis:** |

**Why are you making this referral? Please be as specific as possible about what you are requesting**

|  |
| --- |
|  |

**Permission**

|  |
| --- |
| **Please note, referrals will not be accepted without the permission of the service user you are referring.** **Please advise the client that the IAS are a multi-agency team so information may be accessed by both local authority and health staff who work in the IAS team.****This referral will be discussed at our weekly referral meeting and the individual, GP and referrer (if different) will be notified by letter of the outcome.****Have you discussed this referral with the person? Yes No****Has the person given their permission for this referral to be made? Yes No** |

**Does the Autistic person have a current or previous Statement of Special Educational Needs (SEN)?**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **Don’t know** |

**THIS PAGE IS BLANK.**

**HOWEVER, IF THERE IS ANY ADDITIONAL INFORMATION YOU WISH TO SHARE WITH US PLEASE USE THE SPACE BELOW.**