ADULT REFERRAL FOR A DIAGNOSTIC ASSESSMENT OF AUTISM

Service user's details		
Name:	Title:	DOB:
Preferred name:		
Address:		NHS number:
Email:		Telephone No: Mobile No:
Preferred language:	Ethnicity:	Gender : Sex at birth:
Referrer details		
Name:		Date of referral:
Address:		Relationship to person being referred: Phone:
Email address:		
Have you discussed the referral with the person: Yes ☐ No ☐ Please note, referrals will not be accepted without informed consent. Please advise the client that the IAS is a multi-agency team so information may be accessed by both local authority and health staff.		
GP details (if not referrer):		
Name:	Phone:	
Address:	Email address:	

Other Professionals involved:

	Name	Service	Contact details
1			

2			
3			

Please state why the person is seeking a diagnosis of Autism at this time.

What difference does the person feel a diagnosis of Autism will make to their life.

Development history:

(eg, delays in meeting developmental milestones such as speech; loss of skills they had acquired; unusual behaviour in childhood; differences in interaction and communication; additional educational needs etc)

Social interaction:

(eg, does the person have difficulties: making and/or maintaining relationships; understanding and managing emotions; understanding other people's emotions; understanding social rules etc?)

Social communication:

(eg. Does the person have difficulties in reciprocal communication; unusual speech; repetitive speech; unusual eye contact; reduced facial expression or gesturing; flat intonation problems in understanding such as taking things literally?)

Repetitive/restricted behaviours:
(eg, 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 etc?)
Sensory differences:
(does the person seem to have significant differences in their sensory processing? Eg, 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; getting distressed with too much sensory stimuli; etc)
Has the person had or experiences any of the following:

Problems in obtaining or sustaining education or employment?	
Difficulties in initiating or sustaining social relationships?	
Previous or current contact with mental health or learning disability services. Does the person have another diagnosis?	

Please specify any further documentation enclosed with this referral for further information:
Please comment on any relevant issues relating to risk

Additional information including specific requirements when accessing services:

This referral will be discussed at our weekly referral meeting and you will be notified by letter of the outcome.

Please send this referral to:

Western Bay Integrated Autism Service
Tonna Hospital
Tonna
Neath
SA11 3LX

(Tel 01639 862936)