*Clinician’s Toolkit*



**Sample Referral Form**

ASD Diagnostic Assessment for Children and Young People

Referral Form

Please return completed referral forms to:

Name xxx

Address xxx

Address xxx

Town xxx

Postcode xxx

Or email to xxx

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of child:** | | **Date of birth:** | |
| **Address of child:** | | **Hospital Number:** | |
| **Parent / Carer Name:** | | **Telephone number:** | |
| **School / College:** | | **Other professionals involved:** | |
| **Signs and Symptoms of ASD :** | | | |
| **Social Communication:**  *Include details of level and use of language, level of understanding, use of gesture, body language, facial expression tone of voice and eye contact* | | | |
| **Social Interaction**  *Include details of level of interests in other, ability to seek and provide comfort, empathy, understanding of social rules such as turn taking* | | | |
| **Social imagination**  *Include details of issues with imaginative play or creativity* | | | |
| **Routines, Restricted Interests and Repetitive behaviours**  *Include any difficulties with changes, repetitive behaviours, stereotyped movements and specialist interests* | | | |
| **Sensory Issues**  *Include any unusual responses to sensory stimuli* | | | |
| **Antenatal and perinatal history:**  *Include any significant history including risk factors for ASD* | | | |
| **Developmental milestones:**  *Include any significant issues* | | | |
| **Relevant medical history:**  *include information from any previous assessments* | | | |
| **Any other relevant information:** | | | |
|  | | | |
| **Do any of the following (either currently or historically) apply to the child?** *(Please tick and give details under “any other relevant information”.*) | | | |
| Looked after child | | |  |
| Child protection concerns | | |  |
| Statement of Special Educational Needs (SEN) | | |  |
| **Referrer name and address:** | | | |
| **Signed:** | **Date** | | |

**Consent (to be completed by parent or carer)**

|  |  |
| --- | --- |
|  | |
| **I consent to this referral and the referral process has been explained to me** (please tick to indicate consent) |  |
| **I consent to the assessment team contacting the following professionals for information about my child:** *(if you consent to them being contacted, please list names and contact details of others involved in your child’s care – including school / college)* | |
| **If your child has previously seen a professional for an assessment, please give details below:** | |
| Signed: | Date: |