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| **Integrated Autism Service****Referral Form for Support for an Autistic Adult** |  |
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|  | If you are an adult (over 18 years old) with a formal diagnosis of autism, you can access advice and support from the Integrated Autism Service (IAS). We can offer support to understand autism, short-term direct support, e.g. help to access employment, education, health, functional and recreational activities, access to courses, e.g. post diagnostic support and navigating life, or signpost to other services who can offer further support. |  |
|  |  |  |
|  | **PLEASE NOTE: Service users requesting support must have a formal diagnosis of autism. If you were diagnosed by a different service other than Cwm Taf Morgannwg IAS, please provide proof of diagnosis. We cannot accept a referral without this.** |  |
|  |  |  |
|  | **Section 1: Service User Details** |  |
|  |  |  |
|  | Forename(s): |       | Surname: |       |  |
|  |  |  |  |  |  |  |  |  |  |
|  | Title: |       | Gender: |       | Pronouns: |       |  |
|  |  |  |  |  |  |  |  |
|  | Address: |       | DOB: |       |  |
|  |  |  |  |  |  |
|  |  |  | NHS No: |       *If known* |  |
|  |  |  |  |  |  |
|  |  |  | Hospital No: |       *If known* |  |
|  |  |  |  |  |  |  |  |
|  | Telephone: |       | Email: |       |  |
|  |  |  |  |  |  |  |  |
|  | Ethnic origin: |       | Preferred language: |       |  |
|  |  |  |  |  |  |  |  |
|  | Preferred method of communication:  | [ ]  Telephone [ ]  Letter [ ]  Email [ ]  Text |  |  |
|  |  |  |  |  |  |  |  |
|  | ***If this is a self-referral, go to Section 3.*** |  |
|  |  |  |  |  |  |  |  |
|  | **Section 2: Referrer Details (if self-referral, please leave this section blank)** |  |
|  |  |  |  |  |  |  |  |
|  | Name: |       | Profession/Role: |       |  |
|  |  |  |  |  |  |  |  |
|  | Address: |       | Telephone: |       |  |
|  |  |  |  |  |  |
|  |  |  | Email: |       |  |
|  |  |  |  |  |  |  |
|  |  |  | Relationship: |       |  |
|  |  |  |  |  |  |  |  |
|  | Have you discussed this referral with the service user?*Please note, referrals will not be accepted with without informed consent. Please advise the service user that the IAS is a multi-agency team and information may be accessed by both local authority and health staff.* | [ ]  Yes [ ]  No |  |
|  |  |  |  |  |  |  |  |
|  | **Section 3: GP Details (if the GP is not the referrer)** |  |
|  |  |  |  |  |  |  |  |
|  | GP Name: |       | GP Practice: |       |  |
|  |  |  |  |  |  |  |  |
|  | Telephone: |       | Email:  |       |  |
|  |  |  |  |  |  |  |  |
|  | Address: |       |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **Section 4: Other Professionals Involved** |  |
|  |  |  |  |  |  |  |  |
|  |  | **Name of Professional** | **Service** | **Contact Details** |  |
|  | 1. |       |       |       |  |
|  | 2. |       |       |       |  |
|  | 3. |       |       |       |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **Section 5: Current Diagnosis of Service User** |  |
|  |  |  |  |  |  |  |  |
|  | [ ]  Autism Spectrum Disorder | [ ]  Asperger Syndrome | [ ]  Other (please specify): |  |
|  |  |  |       |  |
|  |  |  |  |  |  |  |  |
|  | Approximate year/ageof diagnosis:  |       | If you were diagnosed by a different service, have you enclosed confirmation of diagnosis? | [ ]  Yes [ ]  No |  |
|  |  |  |  |  |  |  |  |
|  | If you are unable to provide confirmation of diagnosis, please give a reason: |  |
|  |       |  |
|  |  |  |  |  |  |  |  |
|  | **Section 6: Support Requirements** |  |
|  |  |  |  |  |  |  |  |
|  | **What do you want the Integrated Autism Service to help you with? (Please tick ONE)** |  |
|  |  |  |  |  |
|  | [ ]  I would like to be added to the post-diagnostic support course waiting list. I DO NOT need to discuss my support needs in detail with a member of the team at this time. | ***OR*** | [ ]  I would like to discuss my support needs in more detail with a member of the team.If you have ticked the above box, please state your preferred appointment method below:[ ]  Face-to-Face [ ]  Telephone [ ]  Virtual |  |
|  |  |  |  |  |  |  |  |
|  | **Why are you making this referral at this time?***Please be as specific as possible about what you are requesting.* |  |
|  |       |  |
|  |  |  |  |  |  |  |  |
|  | **Please comment on any relevant issues relating to risk; e.g. adult/child protection, criminal justice system/convictions or pending convictions, alcohol/drug dependency, suicidal thoughts/self-harm etc.** |  |
|  |       |  |
|  |  |  |  |  |  |  |  |
|  | **Any additional relevant information, including any help or adjustments you need when accessing the service:** |  |
|  |       |  |
|  |  |  |
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|  | **Section 7: Mailing List** |  |
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|  | IAS sends the following information to autistic adults who are on the mailing list:* Invites to IAS monthly discussion forums,
* IAS quarterly newsletters.

If you would like to be added to the mailing list, please tick here [ ] ***NOTE: Please provide your email address in Section 1.*** |  |
|  |  |  |
|  | **Section 8: Consent (this section must be signed and dated to consent to the referral)**  |  |
|  | [ ]  I do / [ ]  I do not (please tick one) consent to my information being recorded and used by IAS professionals to help them understand the support I need.[ ]  I do / [ ]  I do not consent to my information being included within anonymised data, which will be shared with external partners, e.g Welsh Government, local authorities, for the purpose of monitoring and evaluation of the IAS and future planning of services.I understand that my information may need to be shared with other agencies to ensure I get the most suitable support for me. Please indicate in the table below what agencies you do/do not give consent for IAS to share information with. |  |
|  |  | **Consent** | **Do not consent** |  |
|  | General Practitioner (GP):        |[ ] [ ]   |
|  | Mental Health Services:        |[ ] [ ]   |
|  | Learning Disabilities:        |[ ] [ ]   |
|  | Social Services:        |[ ] [ ]   |
|  | Employer:        |[ ] [ ]   |
|  | Family:        |[ ] [ ]   |
|  | Education:        |[ ] [ ]   |
|  | Other (please specify):        |[ ] [ ]   |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Signature ofService User: |       | Date referral completed:  |       |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Please send the completed referral form to: |  |
|  | * Integrated Autism Service

 Floor 2 Keir Hardie Health Park Aberdare Road  MERTHYR TYDFIL CF48 1BZ | * CTT\_IAS@wales.nhs.uk
* 01443 715044
 |  |
|  | * [www.ctmuhb.nhs.wales/services/integrated-autism-service-ias](http://www.ctmuhb.nhs.wales/services/integrated-autism-service-ias)
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|  | **What happens next?**The referral will be discussed in the weekly multidisciplinary team meeting (MDT). Should the service user be eligible for support;1. If the service user opted for a **post-diagnostic support course only**, they will be placed on a waiting list and contacted when a space becomes available.
2. If the service user opted to **discuss their support needs with a member of the team** and have opted for a **face-to-face appointment**, a letter will be sent to the service user notifying them of the appointment details.
3. If the service user opted to **discuss their support needs with a member of the team** and have opted for a **virtual appointment**, an email will be sent to the email address provided in Section 1 with the appointment details and a Microsoft Teams link for the appointment. NOTE: You will need access to a mobile device, such as a laptop or tablet, that has a built-in camera and microphone.
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