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| **Integrated Autism Service**  **Referral for those who Support an Autistic Adult** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | If you support an autistic adult, you can request support from the Integrated Autism Service (IAS). You can access a post-diagnostic support course designed specifically for those who support autistic adults, receive information and advice, or signpost to other services that may be able to offer further support. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | **Section 1: Supportive Persons Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | Forename(s): |  | | | | | | | | | | | | | | Surname: | |  | | | | | | | | | | | | | | |  | | |
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|  | Title: |  | | | | | | Gender: | | | |  | | | | | | | | Pronouns: | | | | | | |  | | | | | |  | | |
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| NHS No: | | *If known* | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | |
| Hospital No: | | *If known* | | | | | | | | | | | | | | |
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|  | Town: |  | | | | | | | | | | | | | | Postcode: | |  | | | | | | | | | | | | | | |  | | |
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|  | Telephone: |  | | | | | | | | | | | | | | Email: | |  | | | | | | | | | | | | | | |  | | |
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|  | Ethnic Origin: | |  | | | | | | | | | | | | | Preferred language: | | | | | | | |  | | | | | | | | |  | | |
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|  | Preferred method of communication: | | | | | | | | | | Telephone  Letter  Email  Text | | | | | | | | | | | | | | | | | | |  | | |  | | |
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|  | **Section 2: Details of the Autistic Adult** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | Forename(s): |  | | | | | | | | | | | | | | Surname: | |  | | | | | | | | | | | | | | |  | | |
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|  | Title: | | |  | | | | | Gender: | | | |  | | | | | | | | Pronouns: | | | | | | |  | | | | | | |  |
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|  | Address: |  | | | | | | | | | | | | | | DOB: | | | | | |  | | | | | | | | | | |  | | |
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|  | NHS No: | | | | | | *If known* | | | | | | | | | | |  | | |
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|  | Hospital No: | | | | | | *If known* | | | | | | | | | | |  | | |
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|  | Relationship to person seeking support: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | |
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|  | Where did this person receive their diagnosis? | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | |
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|  | **Section 3: Support Requirements** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | **How do you support this person currently?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | **Do you, or the autistic person, currently receive support from any other service?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | **What do you want the Integrated Autism Service to 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 | | | | | | | | | | | | | | | |  | | |
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| **Section 4: Consent (this section must be signed and dated to consent to the referral)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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): | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | |  | |
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|  | Signature of Supporter: | | | |  | | | | | | | | | | Date referral completed: | | | | | | | |  | | | | | | | | | |  | | |
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|  | 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](mailto:CTT_IAS@wales.nhs.uk) * 01443 715044 | | | | | | | | | | | | | | | | | |  | | |
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|  | 🖰 [www.ctmuhb.nhs.wales/services/integrated-autism-service-ias](http://www.ctmuhb.nhs.wales/services/integrated-autism-service-ias) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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