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| **Integrated Autism Service**  **Request for a Professional Consultation** | | | | | | | | | |  | | | | | | | | |
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|  | The Integrated Autism Service (IAS) is able to provide advice, consultation and support to colleagues working in statutory services supporting autistic people. | | | | | | | | | | | | | | | |  | |
|  | ***PLEASE NOTE: In all instances of professional consultation and joint-working, the referring agency retains case management responsibility.*** | | | | | | | | | | | | | | | |  | |
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|  | **Section 1: Professionals Details** | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | |  | |
|  | Full name: |  | | | | | | | Professional role: | |  | | | | | |  | |
|  |  |  | | |  | | | |  | | | | |  | |  |  | |
|  | Service contact details: |  | | | | | | | | | | | | | | |  | |
|  |  |  | | |  | | | |  | | | | |  | |  |  | |
|  | Telephone: |  | | | | | | | Email address: | |  | | | | | |  | |
|  |  | |  | |  | | |  | | | | | |  | |  |  | |
|  | **Section 2: Is the autistic person currently being supported by any of these services?** *(Please tick all that apply)* | | | | | | | | | | | | | | | |  | |
|  |  | |  | |  | | |  | | | | | |  | |  |  | |
|  | Child & Adolescent Mental Health Service (CAMHS) | | | | | Speech & Language Therapy (SALT) | | | | | | Health Visitor/School Health Nurse | | | | |  | |
|  |  | |
|  | Primary Mental Health Services | | | | | Learning Disabilities | | | | | | Third Sector | | | | |  | |
|  |  | |
|  | Secondary Mental Health Services | | | | | Team Around the Family/Wraparound Service | | | | | | Education Pastoral Support Service | | | | |  | |
|  |  | |
|  | Probation/Criminal Justice | | | | | Neurodevelopmental Service | | | | | | Social Services | | | | |  | |
|  |  | |
|  | Other (please specify): | | | | | | | | | | | | | | | |  | |
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|  |  | |  | |  | | |  | | | | | |  | |  |  | |
|  | **Section 3: Please list coexisting diagnoses and any medication(s) for the person being supported.** | | | | | | | | | | | | | | | |  | |
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|  | **Diagnoses:** | | | | | | | | | **Medication(s):** | | | | | | |  | |
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|  | **Section 4: Reason for Consultation** | | | | | | | | | | | | | | | |  | |
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|  | **What outcome do you want the Integrated Autism Service to help you with?** | | | | | | | | | | | | | | | |  | |
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|  | **What is working well?** | | | |  | | |  | | | | | |  | |  |  | |
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|  | **What is not working well?** | | | | | | | | | | | | | | | | |  |
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|  | **Please provide additional information including any known risks, e.g. alcohol, prescription/non-prescription drug dependency, suicidal thoughts, and/or any safeguarding concerns.** | | | | | | | | | | | | | | | | |  |
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|  |  |  | |  | | |  | | | | | |  | |  | | |  |
|  | Signature of Professional: |  | | | | | Date of Referral: | | | | | |  | | | | |  |
|  |  |  | |  | | |  | | | | | |  | |  | | |  |
|  | 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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