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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.*** |  |
|  |  |  |
|  | **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.** |  |
|  |  |  |
|  | **Diagnoses:** | **Medication(s):** |  |
|  |       |       |  |
|  |       |       |  |
|  |       |       |  |
|  |       |       |  |
|  |       |       |  |
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|  | **Section 4: Reason for Consultation** |  |
|  |  |  |  |  |  |  |  |
|  | **What outcome do you want the Integrated Autism Service to help you with?** |  |
|  |       |  |
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|  |  |  |  |  |  |  |  |
|  | **What is working well?** |  |  |  |  |  |
|  |       |  |
|  |  |  |  |  |  |  |  |
|  | **What is not working well?** |  |
|  |       |  |
|  |  |  |  |  |  |  |  |
|  | **Please provide additional information including any known risks, e.g. alcohol, prescription/non-prescription drug dependency, suicidal thoughts, and/or any safeguarding concerns.** |  |
|  |       |  |
|  |  |  |  |  |  |  |  |
|  | 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
* 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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