**Community Child Health**

**Autism Spectrum Disorder**

**Referral Form**

Please complete all sections in as much detail as possible and return to:

Ruth Mappin

ASD/MDT Administrator

Department of Community Paediatrics

New Street Health Centre

Upper New Street

Barnsley

S70 1LP

Please note that incomplete referral forms will not be accepted and will be returned.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Child’s name** | |  | | | **Also known as**  Do not used for adopted children | |  |
| **Gender** | | male □ female □ | | | **Date of Birth** | |  |
| **Home Address:** | | | | | **NHS Number** | |  |
| **Mobile Number** | |  |
| **Home Telephone** | |  |
| **Any allergies?** | |  |
| **Postcode** | |  | | |  | |  |
| **School/Nursery/Playgroup/Childminder (please give name and address)** | | | | |  | | |
| **Ethnicity:** | |  | | | **Religion** | |  |
| **First Language:** | |  | | | **Other Languages** | |  |
| **If the family need an interpreter, what language and dialect:** | | | | | | | |
| **Language:** | |  | | | **Dialect:** | |  |
| **GP practice** | |  | | | | | |
| **Health Visitor / School Nurse** | |  | | | **Health Centre /**  **Telephone** | |  |
| **Consultant / Associate Specialist** | | |  | | | | |
| **Medical Diagnosis** | | |  | | | | |
| **List other professionals who see this child:** | | | | | | | |
| Do you know about any **safeguarding concerns?** | | | | | | |  |
| **If yes,** who will give us more information? | | | | | | | |
| **Name** |  | | | **Telephone number** | |  | |
| Do you know about any **safety risks** to others  e.g. communicable infection, risk of violence and aggression? | | | | | |  | |
| **If yes,** who will give us more information? | | | | | |  | |
| **Name** |  | | | **Telephone number** | |  | |
| Does the parent / legal guardian need help to attend appointments? This about interpreter, wheelchair access, reading and writing problems, learning difficulties, mental health needs | | | | | | | |

Name: NHS No.

|  |  |  |
| --- | --- | --- |
| **Parent(s) / Carer(s) Full Names:** |  | |
| **Relationship to child:** |  | |
| **Signature of parent / carer for consent:** |  | |
| **By signing the referral you are confirming:**   * **You have consent to refer** * This is usually from the person with parental responsibility * It can be from a young person who is competent to give consent | | |
| * **Young person referral**   Does this person give their permission for their parent / legal guardian to know about this referral? | |  |

**Please read the following statement to parents and obtain consent from parents prior to sending the referral:**

“This referral will go to the Autism Spectrum Disorder Assessment Team where it will be discussed and in the event it is accepted, your child will be followed up with a full autism assessment by the Multi Disciplinary Team. You have consented to onward referral and information sharing to other members of the team, and other agencies, as appropriate e.g.

Speech and Language Therapy

Occupational Therapy

Physiotherapy

Dietician

Psychology

Education Services

Health Visitor / Social Care – in relation to early family experiences

In some cases before your child is assessed it may be necessary to gather information from other sources e.g. school, health visitor, social care”.

Do you give permission for other family members to attend appointments? Y / N

If so please identify name and relationship to child / young person

Name…………………………………………………………………………………

Relationship…………………………………………………………………………

Has the BESST team been made aware of the referral? Y / N

Is the BESST team supportive of the referral? Y / N

Name: NHS No.

**A1.**

**Please make comments in regards to concerns in the following areas:**

**Back and forth interaction including verbal and non-verbal:**

**Understanding emotion:**

**Sharing interests:**

**A2.**

**Please make comments in regards to concerns in the following areas:**

**Non-verbal communication:**

**(gesturing / nodding etc.)**

**Eye contact:**

**Gestures:**

**Facial expression:**

**A3.**

**Please make comments in regards to concerns in the following areas:**

**Friendships:**

Name: NHS No.

**Interests in other children:**

**Changing behaviour in different environments:**

**Imaginative play:**

**B1.**

**Please make comments in regards to concerns in the following areas:**

**Repetitive movements e.g. spinning, rocking, lining up of objects, copying words etc:**

**Odd use of language:**

**B2/B3.**

**Please make comments in regards to concerns in the following areas:**

**Routines / rituals / routine change / obsessive behaviours / behaviours during transition within school/home:**

**Strong unusual interests:**

Name: NHS No.

**B4.**

**Please make comments in regards to concerns in the following areas:**

**Hyper or hyperactivity to sensory input or unusual interests in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement):**

**C.**

**Age of onset of parental concerns:**

**Any notable early concerns:**

**Birth history and attachments:**

**(please enclose any supporting information e.g. ASQ, EHC plan, school learning reports)**

**D.**

**Please describe if the child is receiving any extra support in school:**

**Please describe if the child has problems in the following areas:**

**Sleep:**

**Eating:**

**Toileting:**

Name: NHS No.

**Behaviours:**

**Referrers details:**

|  |  |  |
| --- | --- | --- |
| Print name: | Signed: | Date: |
| Job Title: | Telephone number: | |
| Address: | | |