# Autism pathway referral form for diagnostic assessment

South West Yorkshire Partnership
NHS Foundation Trust

**Please use the ADHD Pathway Referral Form for ADHD referrals**

**PART 1: All sections to be completed by the clinician making the referral**

Does the person have a diagnosed global learning disability? YES NO

If YES, we will be unable to accept your referral.
Please contact your local Learning Disability Services.

Date of referral

## Referrer details

Name

Address

Telephone number

Designation

## Details of person referred

Name

NHS number

Date of birth

Current address

Home telephone

Mobile telephone

Has the person consented to this referral? YES NO

Does the person have any communication needs and/or require information in a format other than standard print? YES NO

If YES, what are the person's needs?

Does the person want someone to contact us on their behalf
(e.g. partner, parent) when arranging an initial appointment?     YES     NO

If YES, name and contact details

## GP details

Name

Surgery address

Telephone number

## Autism screening questionnaire

Please review the following statements with the client. We don't have a specific threshold for when a referral is required, but affirmative answers have been associated with people who received a diagnosis of autism by our service.

| **Number** | **Question** | **YES** | **NO** |
|---|---|---|---|
| **1.** | Does the person have difficulty understanding other people? | | |
| **2.** | Did they have any unusual collections including toys which they didn't play with? | | |
| **3.** | Did they engage in pretend play e.g. pretending a stick was a sword or pour water as tea? | | |
| **4.** | Does the person show extremes of negative emotions? | | |
| **5.** | Does the person have significant problems with work or education? | | |
| **6.** | Does the person say inappropriate things to others during conversation? | | |
| **7.** | Is this person good with people? | | |
| **8.** | Does the person have daily routines that cannot be changed? | | |
| **9.** | Does the person have poor eye contact? | | |
| **10.** | Is the person a poor conversationalist? | | |
| **11.** | Is the person literal and doesn't understand jokes? | | |
| **12.** | Does the person have poor relationships with people outside the family? | | |
| **13.** | Does the person have severe difficulty initiating conversation? | | |
| **14.** | Does the person appear awkward to other people? | | |
| **15.** | Is the person socially isolated and lonely? | | |
| **16.** | Does the person have any impairing sensory complaints? | | |

## Please provide examples of the current difficulties the person has in the following areas:

Social interaction

Social communication

Stereotypic, rigid or repetitive behaviours, resistance to change or restricted range of interests

## Has the person had any of the following (provide details):

Problems in obtaining or sustaining education or employment

Difficulties in initiating or sustaining social relationships

Previous or current contact with mental health

A previous diagnosis of a mental health or neurodevelopmental condition (e.g. ADHD, dyslexia, dyspraxia)

## Other professionals involved (e.g. CMHT, psychology)

**A.** Name

Profession

Contact details

Is the person in agreement with the referral? YES NO

What are their expectations from the service?

**B.** Name

Profession

Contact details

Is the person in agreement with the referral? YES NO

What are their expectations from the service?

Have referrals been made to other agencies / organisations? YES NO

If so which?

## Additional information:

**Please use the space below to provide any other relevant information**
e.g. current risks, access to support, what the person wishes to obtain from the assessment

**PART 2 (OPTIONAL): To be completed by a person close to the individual seeking a referral**
It is preferable this is completed by a person who knows you well. Please read the questions and place a tick in the YES or NO box below

| Number | Question | YES | NO |
|---|---|---|---|
| **1.** | During early childhood, did they have intense interests in one or two topics or activities? | | |
| **2.** | Did they have any unusual collections including toys which they didn't play with? | | |
| **3.** | Did they mostly play alongside other children rather than with them? | | |
| **4.** | Did they engage in pretend play e.g. pretending a stick was a sword or pouring water as tea? | | |
| **5.** | Was their eye contact different from other children? | | |
| **6.** | Did they use any unusual language for example overly formal, adult or repetitive language? (For example, more complex vocabulary than peers or repeating phrases) | | |
| **7.** | Did they appear to notice unusual details that others miss? | | |
| **8.** | Did they like to do things over and over again (straight away) in the same way all the time? | | |
| **9.** | Did they find it easy to communicate with other children?  At parties for example | | |
| **10.** | Did they have different and unusual interests to his/her peers? | | |
| **11.** | Did they have difficulty understanding the rules for polite behaviour? | | |
| **12.** | Was their voice unusual (e.g, flat, monotonous, volume)? | | |
| **13.** | Were they bad at turn-taking in conversation? | | |
| **14.** | Did they play imaginatively with other children, and engage in role-play? | | |
| **15.** | Did they often do or say things that were tactless or socially inappropriate? | | |
| **16.** | Were his/her social behaviour very one-sided and always on his/her own terms? | | |
| **17.** | Did they have any sensory difficulties with light, food textures, clothes (labels, socks), certain noises, patterns etc.? | | |
| **18.** | Did they watch other children from the edge of a group or were often alone? | | |
| **19.** | Did they understand humour that others seemed to understand? | | |
| **20.** | Were they alert and interested in others, for example did they not look at others when they approached them? | | |

## ADDITIONAL INFORMATION
## TO BE COMPLETED BY THE PERSON SEEKING A REFERRAL
**Please write anything else you would like us to know**

Please send the completed referral to:

Service for adults with autism,
Manygates Clinic,
Belle Isle Health Park,
Portobello Rd, Wakefield,
WF1 5PN

Or email to ADHDandAutismservice@swyt.nhs.uk

For any queries when completing this referral please contact the team on 01924 316492

If you require a copy of this information in any other format or language please contact your line manager.

With **all of us** in mind.

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