

Referral form

Service for adults with autism

Date of referral

Referrer details

Name

Address

Telephone number

Designation

Details of person referred

Name

NHS number

RiO number

Gender Male □ Female □

Date of birth

Current address

Home telephone

Mobile telephone

Has the person consented to this YES □ NO □

referral?

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

Does the person have a diagnosed global learning YES □ NO □

Disability?

If YES, we will be unable to accept your referral.

Please contact your local Learning Disability Services.

GP details

Name

Surgery address

Telephone number

Reason for referral

Diagnostic assessment Intervention

**Please note:** Referrals for intervention can only be accepted if the diagnosis has already been confirmed. If this is the case please attach a copy of the diagnostic report.

Autism: key features

Please review the following statements with the client. They are to be used as a means to guide your conversation and help you gauge if a referral to a specialist service would be appropriate. We propose that if they agree with **more than 5 statements,** a referral for a specialist diagnostic assessment for autism condition may be appropriate although your clinical judgement should ultimately inform that decision.

Do you find social situations confusing? YES □ NO □

Do you find it hard to make small talk? YES □ NO □

Do you find it difficult to ‘read between YES □ NO □

The lines’ when someone is talking to you?

When you are reading a story, do you find YES □ NO □

It difficult to work out the character’s

intentions?

Do people frequently tell you that YES □ NO □

What you have said is impolite, even

though you think it is polite?

Do you find it difficult to do things YES □ NO □

In a new way?

When reading a story, do you find it YES □ NO □

Difficult to imagine what the characters

May look like?

Do you find making up stories difficult? YES □ NO □

Do you find it difficult to work out YES □ NO □

What someone is thinking or feeling

Just by looking at their face?

Do you do certain things in a very YES □ NO □

Inflexible, repetitive way?

Score (out of 10)

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

Difficulties in initiating or sustaining social relationships

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

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)

1. Name

Profession

Contact details

Is the person in agreement with the referral? YES □ NO □

What are their

expectations from

the service?

1. 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?

JOB NO 6784 AUG 16

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

Please send the completed referral to:

Service for adults with autism, Manygates Clinic, Belle Isle Health Park, Portobello Rd,

Wakefield, WF1 5PN or fax to 01924 360806.

For any queries when completing this referral please contact the team on 01924 316490/92/94