**Referral form for UNDER SCHOOL AGE Children for Autism Service for Scarborough and Ryedale CCG**

**Please note service commissioned only to complete AUTISM DIAGNOSTIC ASSESSMENTS at this time.**

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| This form should be completed by the professional requesting the assessment. Please note that **ALL** sections must be completed. An incomplete referral form may result in a delay in the referral being accepted or a rejection. |

Prior to completing this referral form, please ensure that the referred person **meets the following criteria**:

* **Child is under school age** at the time of the referral.
* **Child has had an assessment by a paediatrician** and the report is included with this referral form.
* **Person is not at risk of harm to self -** being sufficiently stable to keep himself/herself safe throughout assessment, e.g., is not engaging in significant self-harm or attempts on own life.If person engages in significant self-harm or attempts on own life, acceptance of referral will only be considered if person has engaged with regular support and monitoring from local Child and Adolescent Mental Health team.
* **Family/caregivers have given fully informed consent** as indicated on the referral form.
* **Person shows clear difficulties in various areas that form the autism spectrum e.g.,** (i) social communication, friendships, and relationships; (ii) repetitive behaviour and resistance to change; (iii) highly specific interests; (iv) sensory sensitivities.
* **Person is in a stable enough position to undergo the process of an autism assessment**
* Please update us as soon as possible should there be any significant changes to the child/young person’s presentation, risk, or care.

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| **CHILD OR YOUNG PERSON’S DETAILS** | | |
| **Full name:** | | Address: |
| **Preferred name:** | |
| **Date of Birth:** | | Postcode: |
| **NHS Number:** | |  |
| **Identified sex:**  Female  Male  Other………………  *(please specify)* | **Gender the child or young person identifies with:**  Girl/woman  Boy/man  Transgender  Other/prefer not to disclose (circle or specify) | Mobile number:  Home number:  Email:  **Please state the preferred method of communication:** |
| **Language(s) spoken and understood *(include sign language, if relevant):***  Main spoken language English: YES/NO  Is an interpreter required? YES/NO  Language needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **PARENT/CAREGIVERS’ DETAILS** | | | | | | |
| Parent/Caregiver’s full name(s) and relationship to person referred: | | | | | | |
| Parent/Carer address and contact details (if different to the above): | | | | | | |
| Name and address of ALL Parents/Caregivers with legal parental responsibility (if different from above): | | | | | | |
| **Has the person with legal responsibility for the child or young person consented to this referral?** | | | YES | NO |  | |
| **Signature:** | | | **Date:** | | | |
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| **REASON FOR REFERRAL -** *Please explain why you are making this referral. The sections below are areas that we require information to decide if an autism assessment is needed. We have added* ***examples*** *that you might expect to see in a child that should be referred for an autism assessment. Please put a cross in the box next to any of these examples that apply and provide further qualitative evidence of difference and challenges observed in each relevant section.* | | | | | | |
| 1. Language and communication skills | | | | | | |
| *Difficulties using spoken language* |  | *Talks ‘at’ people and little two-way conversations* | | | |  |
| *Difficulties with understanding language* |  | *Struggles to make sustained eye contact or avoids eye contact* | | | |  |
| *Engages in little verbal communication* |  | *Limited use of gestures, such as head nodding or shaking* | | | |  |
| *Struggles to read facial expressions or show emotions on face* |  | *No social chat, preference for talking about own specific interests* | | | |  |
| *Takes language literally* |  | *Repeats spoken language back verbatim* | | | |  |
| *No difficulties in this area* |  |  | | | |  |
| ***PLEASE PROVIDE FURTHER DETAILS & EXAMPLES OF DIFFICULTIES WITH LANGUAGE AND COMMUNICATION SKILLS:*** | | | | | | |
| 1. Social interaction skills with others | | | | | | |
| *Difficulties with making and keeping friends* |  | *Tends to hang back and observe other children but struggling to approach peers* | | | |  |
| *Prefers being around adults or peers from difficult age groups, such as younger children* |  | *Consistently approaches other children in a way that results in conflict/trouble* | | | |  |
| *Takes little interest in other children* |  | *Does not often comfort others* | | | |  |
| *Struggles to share e.g., food, objects of interest* |  | *No difficulties in this area* | | | |  |
| ***PLEASE PROVIDE FURTHER DETAILS & EXAMPLES OF DIFFICULTIES WITH SOCIAL INTERACTION:*** | | | | | | |
| 1. Interests and play skills | | | | | | |
| *Shows little imaginative play or lack of creative writing ability* |  | *Play has a lack of variety and flexibility* | | | |  |
| *Tends to play on their own* |  | *Dominates in play interactions e.g., always needing to be in charge, struggles with turn-taking* | | | |  |
| *Struggles to engage in joint play or activities e.g., often results in conflict, cannot adapt to ideas of others* |  | *No difficulties in this area* | | | |  |
| ***PLEASE PROVIDE FURTHER DETAILS & EXAMPLES OF DIFFICULTIES WITH INTERESTS AND PLAY:*** | | | | | | |
| 1. Repetitive behaviour (motor, vocal or in their play/interests) | | | | | | |
| *Shows repetitive movement e.g., flapping hands, spinning body repetitively, rocking body* |  | *Has highly specific interests that are pursued to an extreme extent (including collecting information on particular topics)* | | | |  |
| *Makes repetitive verbal utterances e.g., repeating same phrases, sounds* |  | *Insists on certain routines e.g., same food items, similar clothing* | | | |  |
| *Engages in repetitive play (lining up toys, replaying same actions over and over)* |  | *No difficulties in this area* | | | |  |
| ***PLEASE PROVIDE FURTHER DETAILS & EXAMPLES OF DIFFICULTIES WITH REPETITIVE BEHAVIOUR:*** | | | | | | |
| 1. Ability to cope with change and transitions | | | | | | |
| *Difficulties with transitioning between activities/settings – or requiring a lot of preparation and support to do this* |  | *Struggles to cope with unexpected changes/events e.g., new teachers, weekend plans, moving furniture* | | | |  |
| *No difficulties in this area* |  |  | | | |  |
| ***PLEASE PROVIDE FURTHER DETAILS & EXAMPLES OF DIFFICULTIES WITH COPING WITH CHANGE AND TRANSITIONS:*** | | | | | | |
| 1. Sensory issues (over- or under-responsive to sounds, touch, etc) | | | | | | |
| *Responds with distress to auditory/visual stimuli* |  | *Dislikes being touched or has preference for tight hugs* | | | |  |
| *Appears distressed in busy environments* |  | *Strong response to any stimuli (or lack of response)* | | | |  |
| *Strong aversion or preference to certain textures and/or tastes* |  | *No difficulties in this area* | | | |  |
| ***PLEASE PROVIDE FURTHER DETAILS & EXAMPLES OF ANY SENSORY DIFFERENCES:*** | | | | | | |
| 1. Behaviour (including any that is causing concern) | | | | | | |
| *Experiences periods of ‘meltdowns’, becoming overstimulated and shutting down* |  | *Extreme anxiety in social situations or new environments* | | | |  |
| *Can demonstrate difficult behaviours towards family/caregivers* |  | *No difficulties in this area* | | | |  |
| ***PLEASE PROVIDE FURTHER DETAILS & EXAMPLES OF DIFFICULTIES IN BEHAVIOUR:*** | | | | | | |
| Have any other associated conditions been identified or considered (e.g., Global Developmental delay, genetic testing, etc.)? *If so, please provide further details.* | | | | | | |
| Please list any diagnoses that have already been used to describe the child/young person’s difficulties and *provide the date these were given if possible*: | | | | | | |
| Are there any concerns about the child or young person’s vision or hearing? | | | | | | |
| Is the child or young person on any medication? *If yes, please specify and the reason(s) prescribed.*  **Does the child take Melatonin?** YES/NO | | | | | | |
| **Please use this box to make us aware of any other information you wish to share that you feel is important and relevant for our team to be aware of regarding the child/young person.** | | | | | | |

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| **PHYSICAL HEALTH*:*** *please detail any concerns about the child’s health.* ***Please attach/forward any reports and additional information that are mentioned and/or relevant to this referral.*** | | | **GP DETAILS** | | |
|  | | | Name: | | |
| Address: | | |
| Tel no: | | |
| **MENTAL HEALTH:** *Please detail any current or historical concerns about the child/young person’s mental health & wellbeing.* | | | **SAFEGUARDING:** *Please detail any current or historical safeguarding concerns* | | |
| *Has there been any concerns regarding risk (e.g., self-harm or suicidal ideation)?* | YES | NO | *Is there any history of trauma?* | YES | NO |
| *If yes, please specify details and dates:* | | | *Has there been any involvement with Social Care?* | YES | NO |
| *If yes, please specify details and dates:* | | |

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| **NURSERY/CHILDCARE SETTING*:*** *Please detail any concerns about participation in these settings, including additional support provided.* | **NURSERY/CHILDCARE SETTING DETAILS *-*** *Be aware that information provided by nursery/childcare setting is relevant for our team to process this referral.* |
|  | Contact Name: |
| Address: |
| Tel no: |

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| **REFERRER DETAILS** | | | | |
| I have discussed the autism assessment pathway with the caregiver(s) and they agree to this referral. | | | | |
| Name: |  | Job Title: |  | |
| Organisation Name: |  | Tel. No: |  | |
| Address: |  | Email: |  | |
| Referrer’s signature: |  | Date: |  | |
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| **TICK TO CONFIRM:** All previous and relevant paediatric reports are attached to this referral form. | | | |  |

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| **PROFESSIONALS CURRENTLY INVOLVED** | | | | | | | | |
| Health Visitor | |  | Occupational Therapist | |  | Social Worker | |  |
| Paediatrician | |  | Physiotherapist | |  | Educational Psychologist | |  |
| Clinical Psychologist | |  | Psychiatrist | |  | Speech & Language Therapist | |  |
| CAMHS worker | |  | Other(s), please list: | |  | | | |
| **Please give details of any professionals who have previously and/or those currently involved, and attach/forward any reports that are available.** | | | | | | | | |
| **Contact Name** | **Organisation & Location** | | | **Date of Involvement** | | | **Report(s) available & attached?** | |
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| **Are there any open referrals or ongoing assessments with other services at the time of this referral?** YES/NO *If yes, please provide further details.* | | | | | | | | |
| **SPECIAL REQUIREMENTS: E.g., Wheelchair Access, formatting correspondence, etc.** | | | | | | | | |
| *If yes, please provide further details.* | | | | | | | | |

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| **Please return completed form to:**  Children and Young People Autism service at The Retreat York - Email: scrccg.retreatautism@nhs.net |

**Privacy Statement**

For the purposes of this form, The Retreat is the data controller responsible for the processing, storage and use of the data. If you have queries relating to how your data is handled then please contact the relevant Administration Lead. Further details about how we handle your data, including the contact details of our Data Protection Officer, can be found in our Privacy Notice at: <https://www.theretreatyork.org.uk/>