**Lifespan Autism and Learning Disabilities [LD] Team**

**DIAGNOSTIC ASSESSMENT REFERRAL FORM**

We accept appropriate referrals for specialist diagnostic assessments for Autism from practitioners only – we do not accept self-referrals.

If the referral is accepted, we offer assessment only and any support required whilst on our waiting list must be provided by the person’s GP/local mental health service.

All referrals must be accompanied by the relevant autism screener from the Autism Research Centre:

1. 16 years +: the self-report Autism Quotient [AQ] and informant-completed Relatives Questionnaire [RQ]
2. 12-15 years: the informant-completed Adolescent Autism Quotient [AQ]
3. 4-11 years: the informant-completed Cambridge University Behaviour and Personality Questionnaire

for Children

The screeners can be downloaded from [www.autismresearchcentre.com/arc\_tests](http://www.autismresearchcentre.com/arc_tests).

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| **Date of Referral** | **DD / MM / YYYY** |  |

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| **Section 1: Patient & Family Details** | | | | | | | | | | | | | | | | |
| **I am requesting an autism assessment** | | | | | | | | | | | **Yes** | | | | **No** | |
| **Has the young person agreed to this referral?** | | | | | | | | | | | **Yes** | | | | **No** | |
| **Name of the parent/carer who consented to this referral** | | | | | | | | | | |  | | | | | |
| **Patient’s Full Name** | | |  | | | | | **Date of birth** | | | **DD / MM / YYYY** | | | | | |
| **Preferred name** *(if different)* | | |  | | | | | **Sex** | | | **Female** | | | | **Male** | |
| **Is the gender the patient identifies with the same as their sex registered at birth?** *(voluntary question, so can be left blank if preferred)* | | | **Yes** | | | | | **No** | | | | | | | **Term** | |
| Select "Yes" if the patient identifies as female and their sex registered at birth was female or if the patient identifies as male and their sex registered at birth was male  Select "No" if the patient’s gender identity is different to the sex recorded on their birth certificate when they were born, e.g., if they are transgender or non-binary. If you answered "No", please give the term the patient uses to describe their gender | | | | | | | | | | | | | |
| **Address** | | | **POSTCODE:** | | | | | **Patient Phone / Mobile** | | |  | | | | | |
| **Carer Phone / Mobile** | | |  | | | | | |
| **Patient NHS Number** | | |  | | | | | **Patient email** | | |  | | | | | |
| **Int*e*rpreter Required?** | | | **Yes** | | **No** | | | **If required, what language** | | |  | | | | | |
| **Has the patient ever been in receipt of Free School Meals?** | | | | | **Yes**  **No**  **Don’t know** | | | | | | | | | | | |
| **Does the patient have any other communication support needs**? | | | **Yes** | | **No** | | | **If yes, please give more information** | | |  | | | | | |
| **Who does patient live with?** | | |  | | | | | **Is the patient a dependent of an ex-member of British armed forces?** | | | **No**  **Don’t Know**  **Yes, dependant of an ex-services member** | | | | | |
| **Ethnicity Code** | | |  | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Ethnicity codes** | | | | | (A) White British  (B) White Irish  (C) Other White background  (D) White & Black Caribbean | (E) White and Black African  (F) White and Asian  (G) Other mixed background  (H) Indian | (J) Pakistani  (K) Bangladeshi  (L) Other Asian background  (M) Caribbean | (N) African  (P) Other Black background  (R) Chinese  (S) Any other ethnicity group | | | | | | | | | | | | | | | | | |
| **Family Members** *relevant to referral* | | | | | | | | **Relationship** | | | **Living at above address Y/N** | | | | **DOB** | **M/F** |
| **First Name** | | | | **Surname** | | | |
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| **Who has Parental Responsibility?** | | | | | |  | | | | | | | | | | |
| **Please tick those that apply:** | | | | | | | | | | | | | | | | |
| **Child in Need** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Child Protection Plan** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Looked After Child** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Special Guardianship Order** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Residence Order** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Adopted** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Youth Offending Order** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Previous CAMHS Involvement** | | | | | | **Yes** | | | **No** | | | | **Historic** | | | |
| **Section 2: Professional Network** | | | | | | | | | | | | | | | | |
| **GP Details** | | | | | | | | | | | | | | | | |
| **GP Name** |  | | | | | | **GP Practice Name** | | |  | | | | | | |
| **GP Address** | **POSTCODE:** | | | | | | **GP Telephone** | | |  | | | | | | |
| **Permission to Contact?** | | | **Yes** | | **No** | | **Don’t Know** | | |
| **Education &Training Details [if applicable]** | | | | | | | | | | | | | | | | |
| **School/training provider name** |  | | | | | | **Name of contact and role** | | |  | | | | | | |
| **School/training provider address** | **POSTCODE:** | | | | | | **School Telephone** | | |  | | | | | | |
| **Permission to Contact?** | | | **Yes** | | **No** | | **Don’t Know** | | |
| **Referrer Details** | | | | | | | | | | | | | | | | |
| **Referrer Name** | |  | | | | | **Referrer Job Title** | | |  | | | | | | |
| **Referrer service name and address** | | **POSTCODE:** | | | | | **Referrer Email** | | |  | | | | | | |
| **Referrer Telephone** | | |  | | | | | | |

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| **Section 3: Patient’s current situation / desired outcomes** | | | | | |
| Include information about the patient’s strengths and what is going well, as well as what the key concerns or issues are. The section on outcomes should include what the patient would like to gain from this assessment, as well as the family’s best hopes, specifying what they know about the referral to Lifespan. We do not accept referrals for patients who do not know/have not consented to the referral. | | | | | |
| **Strengths/what is going well** |  | | | | |
| **Key presenting issues/concerns or difficulties** |  | | | | |
| **Trigger for seeking autism assessment** |  | | | | |
| **Any significant life changes or stressful events that have occurred in the past or more recently** |  | | | | |
| **Outcome of discussion with the patient and family about the referral – their views, etc.** | *Please ensure you document the outcome of the discussion with the young person regarding their consent for this referral – if the young person has not been consulted (and where applicable, given their consent), the referral will be returned* | | | | |
| **Information on people in the family who have had or currently have physical or mental health conditions (incl. autism/LD), as well as the family member’s relationship to the client (e.g., mother, father, sibling, aunt, uncle, grandparent, etc.)**  *if this section is not relevant, you can leave it blank* | Alcohol/substance abuse | **Yes** | **No** | Family Member |  |
| Anxiety | **Yes** | **No** | Family Member |  |
| Autism | **Yes** | **No** | Family Member |  |
| Attention Deficit | **Yes** | **No** | Family Member |  |
| Depression | **Yes** | **No** | Family Member |  |
| Eating Disorders | **Yes** | **No** | Family Member |  |
| Learning Disability | **Yes** | **No** | Family Member |  |
| Personality Disorder | **Yes** | **No** | Family Member |  |
| Phobia(s) | **Yes** | **No** | Family Member |  |
| Obsessions/  Compulsions | **Yes** | **No** | Family Member |  |
| Tics | **Yes** | **No** | Family Member |  |
| Tourette’s | **Yes** | **No** | Family Member |  |
| Schizophrenia | **Yes** | **No** | Family Member |  |
| Suicide/Suicide attempts | **Yes** | **No** | Family Member |  |
| Other: | | | Family Member |  |
| **Section 4: Patient Developmental & Medical History** | | | | | |
| **How old was the patient when there was first a worry about their development?** |  | | | | |
| **What were the concerns at this time? Who shared these concerns/who disagreed?** |  | | | | |
| **Previous health service involvement**  *Name(s) of practitioners, dates involved, reason(s) for ending treatment, etc.* |  | | | | |
| **Current prescription and/or psychiatric medication**  *Please list and provide dates and prescriber name* |  | | | | |
| **Section 5: Mental health services involvement and risk assessment – if this section is not completed in full, it will be returned** | | | | | |
| **Current mental health service involvement**  *Attach care plan* ***or*** *outline service(s) currently provided, by whom, timeframes, intended outcomes, etc.* |  | | | | |
| **Name of Care**  **Co-ordinator** |  | | | | |
| **Risk assessment** *this section must be completed – if not, the referral will be returned* | **Please complete the following information as fully as possible.**  **Risk to self:**  -Is the young person having thoughts of suicide or thinking they would be better off dead?  -Has the young person ever tried to end their life? (Please comment on means and outcome)  -Are you concerned about the young person’s current intention to end their life?  -Have they made plans to end their life?  -Has the young person ever self-harmed? If so, how?  -Has the young person self-harmed recently? (Please comment on means, frequency and severity)  -Please provide details of any recent A&E visits or inpatient admissions, if applicable.  **Risk to others:**  **Risk from others:**  **Crisis plan Yes □ No □**  *If yes, please attach crisis plan to referral* | | | | |
| **Section 6: Education / employment** | | | | | |
| **Further details on employment history and current provision** |  | | | | |
| **Section 7: Social Communication Profile** | | | | | |
| In this section, we would like to get further information from you about the client’s communication, relationships, sensory preferences and interests/activities. Providing information about their past history (e.g., if they had difficulties with sustaining friendships in secondary school) and about their current profile would be helpful. Outlining if they are the same or different across contexts (e.g., at home or in school) would be helpful also. It is essential that this section is completed by a practitioner, not a member of the family/the client themselves – we need to understand how the patient may present to someone who does not know them as well as a family member. | | | | | |
| **Social communication and interaction** | | | | | |
| **Spoken language**  *e.g., use of spoken language, tone, repetitions in speech, oddly formal style or use of idiosyncratic words* |  | | | | |
| **Social reciprocity** | *e.g. back-and-forth flow of social interaction, social approaches to others in and outside of the family, back and forth conversation, social chit-chat, initiating social interaction with others, responding to other people’s social initiation, how they share their interests and emotions with others, labelling feelings correctly, knowing and understanding emotional states, accepting their own emotions/emotions of others, describing their own feelings/feelings of others* | | | | |
| **Non-verbal communicative behaviours** | | | | | |
| *Eye contact, body language, gestures, facial expression* | | | | | |
| **Relationships** | | | | | |
| *Developing, maintaining and understanding relationships, making and keeping friends, interest in peers, relating to others outside of the family, bullying or loneliness, adjusting behaviour to suit social contexts, play and imagination* | | | | | |
| **Restricted and repetitive patterns of behaviour, interest or activities** | | | | | |
| *Repetitive speech or motor movements, lining objects up/flipping objects* | | | | | |
| *Managing routines and transitions, coping with change and uncertainty, response to things being different to how they were previously or how they are expecting them to be, rituals* | | | | | |
| *Attachment to unusual objects, intense special interests/preferred topics of conversation* | | | | | |
| *Response to sensory aspects – smells, sounds, light, etc.; interests in sensory aspects of the environment (sniffing, licking, smelling, touching objects), apparent indifference to pain/temperature* | | | | | |
| **Please add any other information you feel would be helpful for us to know** | | | | | |
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**Thank you**