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| The North Yorkshire Autism & ADHD Service Referral Form |

**Before making this referral, please note**

Assessment is a challenging process for anybody. Therefore, we will onlybe able to accept referrals that **meet the following criteria**:

* **Person is 18 years old or above** at the time of the referral.
* **Person is not at risk to self** being sufficiently stable to keep himself/herself safe throughout assessment, i.e. is not engaging in significant self-harm or attempts on own life.
* **Person is not at risk of harming others** such that the assessor or other people accessing the service will be safe from physical attack.
* **Person’s substances and/or alcohol** use is not at a level that may interfere with observational assessments/ability to engage in assessment process.
* **Person’s BMI** is above15.
* **Person’s IQ is more than 70** meaning that he/she does not have a moderate or severe learning disability.
* **Person does not have dementia** and is not going through the diagnostic process for dementia.
* **Person has given fully informed consent** as indicated below.

*If you are at all unsure about whether the individual would qualify, please contact us, using the contact details at the bottom of this page.*

***We require all referrals to include an initial screening. Please attach the initial screening forms:-***

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| **AQ 10 (Autism Referrals)** | Score: |
| <http://docs.autismresearchcentre.com/tests/AQ10.pdf> |  |
| **ADHD scale** | Score: |
| [Wender Utah Rating Scale (Adult ADHD)](https://www.valeofyorkccg.nhs.uk/rss/data/uploads/adult-autism-and-adhd/wender-utah-nov-2018.docx) |  |

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| **Reason for referral (please indicate)** | Autism Diagnostic Assessment  ADHD Diagnostic Assessment |
| **Does the person consent to this referral?** | Yes  No |
| **Please specify name and contact details of other people the individual consents to being contacted (eg. parents)** | Name:  Phone number:  Email: |

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| **Patient Name** |  | | |
| **NHS Number** |  | **Patient’s CCG** |  |
| **Date of Birth** |  | | |
| **Contact Details** | Address: | | |
| Telephone: | | Mobile: |
| Email: | | |
| **Best way to contact individual (please indicate)** | Telephone  Text | | |
| Mobile  Email | | |
| Post | | |
| **Registered GP details** |  | | |
| **Other agencies involved (specify contact details)** |  | | |
| **Summary of**  **Difficulties (AUTISM)**  The characteristics of autism are generally divided  into three main groups (examples given). **Please give examples** for **all three areas** where possible.  Please use tick boxes and add additional information where possible. | **Please only fill in section in if you are referring for Autism assessment**  **1) Social Communication**  diff. with verbal and non-verbal communication (avoiding eye contact/diff. understanding facial expressions)  diff. starting/maintaining/give-and-take of conversation, literal understanding of language, diff. understanding jokes/sarcasm  **2) Social interaction**  diff. understanding other’s emotions/point of view  diff. fitting in socially  diff. initiating and maintaining relationships  preferring to spend time alone, finding people confusing/unpredictable  **3) a) Routines/Rituals; b) Highly focussed and intense interests; c) sensory sensitivities**  fixed daily routines  uncomfortable with change, cope better with preparation  intense interest in specific, highly focussed areas of interest  hyper-/hyposensitive to one or more senses  **4) Have the above difficulties been long standing** (ie since childhood or adolescence)**?** | | |
| **Summary of**  **Difficulties (ADHD)**  Please give examples for **all areas** where possible. | **Please only fill in section in if you are referring for ADHD assessment**  **1) Attention and concentration**  **2) Organisation skills**  **3) Restlessness, diff. keeping quiet, irritability/quick temper**  **4) Have the above difficulties been long standing** (ie since childhood or adolescence)**?** | | |
| **Current/co-existing mental health or history of mental health issues and risks to self and others** | *Please attach relevant mental health reports* | | |
| **In your opinion, is this person stable enough to cope with the assessment process?**  **Yes  No  Don’t know** | | | |

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| **Current Medication (please attach copy of health record)** | |  |
| **Any physical health problems (please attach any relevant reports)** | |  |
| **Any reasonable adjustments needed?** | *E.g. accessible entrance, communication aids.* | |
| **Is an interpreter required?** | *Please provide full details* | |

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| **Date of Referral** |  |
| **Referrer Name & Contact Details** |  |
| **Profession** |  |

***Autism and ADHD service use only***

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| *Date referral received:* |
| *Date discussed in referral meeting:* |
| *Any further information needed:* |
| ***Acceptance of referral*** Yes  No |
| *Next Steps:* |