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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 [x]  No [x]  |
| **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 dividedinto 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:*  |