Barnsley Community Child Health

Assessment for Autism Spectrum Disorder

Referral Form 2019/2020 (v.4)

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| **ASDAT Referral – Notes to referrer.**  **Pre-completion notes:**  **EARLY HELP ASSESSMENTS (EHA) -** Referrals will only be considered where there is an active EHA and there is clear evidence that the child’s needs have been addressed through this process.  Please ensure that all points below are checked before submission of this referral. Any referral form that is incomplete will automatically be rejected and returned to the originating referrer.  This is a two part referral. Once section one is completed, both sections are to be passed to the child’s educational setting for completion of section two. The person completing section one of this form will be the main professional contact for this referral.  **Pre-completion checklist.**   * This is a professional only referral; parents are unable to self refer to ASDAT. * This is a two part referral and both sections must be fully completed prior to submission. * The form can be either hand written or typed however, please ensure that any hand written forms are completed in black/blue ink and are legible. * When completing, be sure to give clear identifiable examples in all areas. Minimal information is likely to result in the referral being rejected at panel. * Identifiable needs should be highlighted in all areas. * If sensory difficulties are the main issue, please refer to occupational therapy. * If behaviour difficulties without social/communication issues are the main concerns, please consider referral to family centres. * Please make it clear who is providing the information which is being documented in this referral. eg, “Mum states…………” or “I have observed…….” * If this child is known to a community paediatrician, this must be discussed with them prior to submission. |

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| **Pre-Submission checklist.** |  | YES |  | NO |
| 1. This child has an active EHA. *Please give further details on page 2.* |  |  |  |  |
| 1. Has enough information with clear examples been provided? |  |  |  |  |
| 1. Has section one been fully completed? |  |  |  |  |
| 1. Has this section been signed by parents [end of section 1]? |  |  |  |  |
| 1. Has the GDPR section been signed [end of section 1]? |  |  |  |  |
| 1. Has this section been signed by you (the referrer) [end of section 1]? |  |  |  |  |
| 1. Has section two been fully completed? |  |  |  |  |
| 1. All pages are stapled together to ensure data safety. |  |  |  |  |
| 1. If this child is known to a community paediatrician, have you discussed this referral with them? *Please indicate the date you spoke to them.* |  |  |  |  |

**You must be able to answer yes to all of the above prior to submitting.**

Barnsley Community Child Health

Assessment for Autism Spectrum Disorder

Referral Form

**SECTION - 1**

This is a two-part referral; the first section is to be completed by the referring professional and the second section to be completed by the educational setting. Please note that all incomplete referrals will be returned to you for more information prior to consideration.

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| Child’s Details |
| |  |  |  |  | | --- | --- | --- | --- | | **Child’s name** |  | | | | **Date of birth** |  | **NHS number / UN** |  | | **Gender** |  | **Also known as**  *Do not use for adopted children.* |  |  |  |  | | --- | --- | | **Home address** |  | | **Postcode** |  | |

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| Additional information |
| |  |  |  |  | | --- | --- | --- | --- | | **Ethnicity** | **Religion** | **First Language** | **Other Languages** | |  |  |  |  | | *If an interpreter is required, what language and dialect?* | | | | | **Language** |  | **Dialect** |  | |

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| Medical details | Early Help Assessment and Safeguarding |
| |  |  | | --- | --- | | **Known allergies** |  | | **Medical diagnosis** |  |  |  |  | | --- | --- | | **GP’s address contact number** |  | | **Health visitor / school nurse** |  | | **Consultant / Ass. Specialist** |  | | |  |  |  | | --- | --- | --- | | **Early Help Assessment URN** | **Date opened** | **Date of last review** | |  |  |  |  |  |  |  | | --- | --- | --- | | **Child In need**  **Plan (CIN)** | **Child protection plan (CP)** | **Looked after child** | |  |  |  |  |  |  | | --- | --- | | **Name of lead professional** | **Organisation** | |  |  | | **Tel/email** | | |  | |  |  | | --- | | ***PANEL STAMP, For internal use only!*** | |

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| Details of significant others |
| **Parent / carers details**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Name** | **Current contact number** | **Relationship to child** | **Parental responsibility?** | **Currently living in the family home?** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   **Other adults living within the family home**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Name** | **Relationship to child** |  | **Name (please print)** | **Relationship to child** | |  |  |  |  |  |  |  |  | | --- | --- | | **Number of siblings?** |  | |

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| Multi agency involvement |
| *Please detail any other agency/professional currently involved with the family (eg, IDAS, Family Centres)*   |  |  |  |  | | --- | --- | --- | --- | | **Name** | **Agency** | **Contact details** | **Reason for involvement** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

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| Please detail any known risk to working with this family either in clinical settings or in the family home! |
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| *Referrers’ details – this is the professional who has completed the section one of this form.* |
| |  |  |  |  | | --- | --- | --- | --- | | **Name** |  | **Job Title** |  | | **Agency** |  | **Contact number** |  | | **Address** |  | | | | **Email address** |  | | | | **Date of completion** |  |  |  | |

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| Please complete the following sections ensuring you provide as much information as possible including your own professional opinion and the views of the parent/carer/child whilst ensuring you provide details and examples of any concerns.  **NB: - Identifiable needs should be highlighted in all areas with clear examples given.**  **- If sensory difficulties are the main issue, please refer to occupational therapy.**  **- If behaviour difficulties without social/communication issues are the main issue, please consider referral to family centres.** |

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| *Please describe the child’s* **Social, Emotional/communication & interaction skills** |
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| *Please describe the child’s* **Non-verbal communication skills** |
| **Think about things such as eye contact, facial expressions and use of gesturing** |

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| *Please describe the child’s* **Friendships, relationships with peers, creativity and imagination** |
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| *Please describe any* ***abnormal movements, repetitive behaviours, obsessive interests and ability to cope with change*** |
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| *Please describe the child’s* **Sensory difficulties to noise, textures etc.** |
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| *Additional information* |
| **Age of onset of parental concerns:**  **Any notable early concerns with early attachment or any history of domestic abuse within the homes? (give details)** |

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| **General Data Protection Regulation (GDPR)**  **What information will be used?**  Throughout this process we will need to obtain information about your child’s strengths and developmental concerns both at home and in school or nursery. This may include information around their social skills, communications skills, areas of interest, behaviours and sensory needs. This information may be collated via clinics, observations, questionnaire and phone calls.  **What will we do with your information?**  Information collected during this process will be stored safely in your child’s hospital notes. This information will be use to aid and inform the assessment. Information will be relevant, factual and appropriate for the purpose of assessment. Other services involved in the assessment process may also keep their own records, please contact them directly for further information.  **Sharing of information**  In order to fully understand how your child manages in a variety of situations and setting, we will need to source supporting information from other professionals who may know your child. This may include Speech and Language Therapy, Occupational Therapy, Physiotherapy, Dietician, Psychology, Education Services, Health Visitor / Social Care (in relation to early family experiences) or other services.  As part of the multi-agency assessment process, a multi-disciplinary team (MDT) professionals meeting will be held and all relevant information which has been obtained throughout will be discussed with the team for purpose of assessment.  Without obtaining and sharing this information, we will not be able to undertake the assessment. |
| To be completed by parent/carer with PR responsibility  I/we agree that the ASDAT team can obtain and share information from/with relevant professionals involved in the assessment of my child.  I/we have read the above statement and confirm that I/we understand why this information is needed and the importance of sharing it.  By signing this, you are giving consent to all of the above.  **Print name: Signature: Date: / /**  **Relationship to child:** |

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| **Consent to refer** |
| |  |  | | --- | --- | | **Parent / Carer / Young person** *(please circle as appropriate)* | **Referrer** | | **By signing this referral you are confirming:**   * You have given the referrer *(the person completing this form)* consent to submit this referral to the community paediatric team (ASDAT Panel) for consideration.   **If referral is completed with a young person,** does this person give their permission for their parent/legal guardian to know about this referral? **YES / NO** | **By signing the referral you are confirming:**   * You have used the pre-submission checklist to ensure all required information is included, and * The Young person is aware that they are going to be referred to ASDAT *(if of age/understanding).* * If accepted to the ASD assessment pathway, it is the referrer’s responsibility to support the child/young person and family until the MDT assessment process starts which may take up to 24 months. | | **Name *(please print)*** | **Name *(please print)*** | | **Signature** | **Signature** | | **Date:** | **Date:** | |

**Barnsley Community Child Health**

Autism Spectrum Disorder

Referral Form

**SECTION 2**

**Supporting information from educational setting**

*This section does not have to be completed if the child/young person is home schooled.*

*If section one has been completed by the educational setting, you only need to complete the section below and columns two and three of the following table.*

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| **Educational setting details** |
| |  |  |  |  | | --- | --- | --- | --- | | **Child’s Full name** | **Date of Birth** | **Class** | **Year** | |  |  |  |  |  |  |  |  | | --- | --- | --- | | **Setting Name** | **Setting address** | **Contact number** | |  |  |  | |

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| **Key contacts** |
| |  |  | | --- | --- | | **Name of key worker / teacher** | **Contact number** | |  |  |  |  |  | | --- | --- | | **Name of SENCO** | **Contact number** | |  |  |  |  |  | | --- | --- | | **Name of person completing this form** | **Contact number** | |  |  |  |  |  | | --- | --- | | **Date section 2 completed** |  | |

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| **Additional educational support** *– please detail any additional support / plans in place in school.* |
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**Please provide as much detail as possible based on what has been observed within school / nursery. This section is not for parental concerns.**

***If the table headers are missing from this form, please contact the ASDAT team, thank you.***

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| --- | --- | --- | --- |
|  | **What are your concerns in this area?** | **What strategies have been implemented in school?** | **What progress has been seen?** |
| **Social emotional / communication and interaction skills** |  |  |  |
| **Non-verbal communication skills** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **What are your concerns in this area?** | **What strategies have been implemented in school?** | **What progress has been seen?** |
| **Friendships, relationships with others, creativity and imagination** |  |  |  |
| **Abnormal movements, repetitive behaviours, obsessions, ability to cope with change** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **What are your concerns in this area?** | **What strategies have been implemented in school?** | **What progress has been seen?** |
| **Sensory difficulties** |  |  |  |
| **Other details** |  |  |  |

**Please ensure that all the relevant sections are completed prior using the pre-submission checklist provided. Referrals without the required information will be returned to sender.**

**Please submit to:**

**Autism Assessment Team**

**Barnsley Community Paediatrics Team**

**New Street Health Centre**

**Upper New Street**

**Barnsley, S70 1LP**

**T: 01226 644 876**

**-OR-**

**Secure email to barnsley.asdat@nhs.net**