**Consent Form (ASC2)**

**Autism Spectrum Disorder**

**Assessment Team (ASDAT)**

Community Paediatrics

**It is important that you fully understand how your details will be used throughout this assessment process and how it will be obtained and shared. Therefore, please ensure you read the following statement prior to signing this form.**

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| **General Data Protection Regulation (GDPR) Statement** |
| **Sharing of information**As part of the assessment process, additional information will be sourced from other agencies and professionals such as Paediatric Therapy Teams (SALT, OT, Physio), CAMHS, Education (School, EP, EWO), Health (CAMHS, GP, 0-19) and support services (Family support, Social Care). As this is a multi-agency assessment, information gathered will be exchanged as nessessary. A copy of your child’s assessment may be sent to your GP, Social Worker or school for their future records. **What is the information used for?** The information is used soley for the purpose of this assessment. By collating such information, we hope to be able to secure evidence needed to conclude the assessment process. **What will we do with your information?**Information collected during this process will be stored in your child’s hospital notes. 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. **Without obtaining and sharing this information, we will not be able to undertake the assessment.** |

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| **Details of child who this assessment is being requested for** |
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| **Child’s name** |  | **Date of birth** |  |

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| **Consent from an adult with parental responsibility.** |
| Please tick 🗹 or initial each statement to express your consent*NOTE: We will be unable to proceed with an assessment without this consent.* | Yes/No/NA |
| **1** | Having read the above statement, I/we consent for our information to be obtained, shared and used between agencies as required for the purpose of this assessment. |  |
| **2** | **Parent/Carer (children >11):** The young person is aware that this referral is being made and knows what they are being assessed for? |  |
| **3** | **Parent/Carer (children <16):** I/we give consent for this Assessment on our child’s behalf. |  |
| **4** | **Parent/Carer (children >16):** The young person gives consent to this assessment. |  |
| **5** | I/we consent to our child being observed in school where nessessary to gather further evidence. |  |
| **5** | All parties with Parental Responsibility (PR) consent to this assessment. |  |

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| **Name of person(s) providing consent** | **Relationship to child** | **Do you have PR?** | **Signature *(digital signature is not valid)*** | **Date** |
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