**Parent / Carer Supporting Information (ASC3)**

**Autism Spectrum Disorder**

**Assessment Team (ASDAT)**

Community Paediatrics

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| Dear Parent(s) / Carer(s)You are being asked to complete this form to support a request for an autism assessment for your child. This information will be used in conjunction with the information provided by school and any other supporting professional to determine if an autism assessment is appropriate. **Please read the following notes carefully prior to completing the form.**1. Please type or print the information required using black ink – if the form is illegible, it may be rejected.
2. Please try to provide clear and to the point examples which are relevant to the topic header.
3. Once completed, please return this information to the professional co-ordinating the referral.
4. If a question is not relevant for your child, please mark with ‘n/a’ or ‘no concern’s so we know this hasn’t been missed.
5. If you need support to complete this form, please speak with your health visitor, school nurse, SENDCo or Family Support Worker.
6. This form should be returned to the professional coordinating the referral and should not be submitted directly to the assessment team without the other accompanying forms.
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| **Child’s Details** |
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| **Child’s name** |  | **Home address *Inc. postcode.*** |
| **Date of birth** |  | **NHS number / UN** |  |  |
| **Gender at birth** |  | **Also known as***Do not use for adopted children.* |  |

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| **Is or has your child been supported by any of the following professionals.** |
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|  | ✓ | Name, Agency and Contact number |
| Community Speech & Language Therapist |  |  |
| Community Occupational Therapist |  |  |
| Educational or Clinical Psychologist |  |  |
| SCI Team |  |  |
| Portage |  |  |
| Family Support Worker |  |  |
| Health Visitor / School Nurse |  |  |
| Social Worker |  |  |
| Early Help Assessment (EHA)***Inc. Date last review, URN*** |  |  |
| Other |  |  |

**\*\* Please attached last EHA review and any reports that would support this referral.** |

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| **Parent(s) / Carers(s) information** |
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| **Name** | **Relationship to child** | **Contact Number**  | **Parental** **responsibility?** |
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| **Family History** |
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|  | **Yes /** **No** | **Please provide further details.** |
| Do you, your partner or any of your other children have a diagnosis of autism? |  |  |
| Has this child had a previous assessment for autism? |  |  |
| Is there a family history of learning disabilities or genetic conditions? |  |  |
| Have the difficulties been present since a young age? What age? |  |  |
| Has this child ever been assessed for ADHD? If so, what was the outcome? |  |  |
| Has this child received any other diagnosis such as: Asperger’s, Dyslexia or Epilepsy? |  |  |
| Are you completing this referral with the child?  |  |  |

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| **What is your child good at? What are their strengths? What make you proud?** |
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| **Are there any family, domestic or environmental factors you feel we need to be aware of?** |
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| **Social Communication and Interaction.** |
| Please describe your child’s **Verbal Communication and interaction skills**, what are your concerns? Things to think about when completing this:* **The way they speak:** unusual pitch, tone, volume, accent, phrases or use of language,
* **Who they speak to:** non-verbal, limited language, speaks to anyone and everyone
* **When will they speak:** only around their own chosen topic, only in certain company, only to communicate a need
* **Understanding:** do they understand jokes and sarcasm; can they follow instructions, can they hold a two-way conversation?
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| Please describe your child’s **Non-verbal Communication and interaction skills**, what are your concerns? Things to think about when completing this:* **Recognition**: Can they follow a finger point? Can they tell when you are happy, cross or sad? Can they read body language?
* **Use**: Will they use gestures to support language (pointing whilst showing you something), do they rely more on non-verbal than verbal to communicate?
* **Reflecting:** Does their body language reflect what they are saying or how they are feeling.
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| Please describe your child’s **Friendships and relationships with others**, what are your concerns? Things to think about when completing this:* **Peers**: Do they have friends or acquaintances? Do they have a best friend? Can they make and maintain friendships?
* **Adults**: Do they have stranger awareness? Will they speak with familiar adults?
* **Social Awareness:** Can they adapt behaviours according the environment or situation, will they talk overs other, appear rude, abrupt or uncaring. Can they take turns or share?
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| **Self-Stimulatory Movements and Speech (STIMS)** |
| Please describe any **repetitive or unusual speech, movement or use of objects** that your child displaysThings to think about when completing this:* **Speech:** Unusual phrases, repetitive sayings, repeating what others say.
* **Movement:** Tiptoe walking, spinning, hand flapping, rocking, facial grimacing.
* **Objects:** Doesn’t use toys for play, spinning wheels on toy cars/prams.
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| Does your child display any **Special Interests (SPINS)** which pre-occupy their mind?Things to think about when completing this:* Knows everything there is to know about hoovers, dinosaurs, aeroplanes etc
* Only interested in 1 particular item or toy and won’t entertain anything else
* Everything they talk about or do has to involve said interest
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| Please comment on how your child responds to **routines, the need for routines and changes to routine.**  |
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| Does you child appear to **seek or avoid sensory input** on a day to day basis? Do they overreact or underreact to certain things?Things to think about when completing this:* Touch, taste, smell, sound, visual or movement.
* Do they feel pain like others?
* What is their diet like?
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| **Need for referral** |
| Why do you feel this referral is needed, what are your worries?  |
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| **Impact on day to day life** |
| Considering the information you have provided above, how would you rate the impact these difficulties have on your child’s day to day life.  |
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|  | **0****No impact on day to day life** | **1****Minimal impact on day to day life** | **2****Some impact on day to day life** | **3****Most days are impacted** | **4****Every day is impacted** | **5****All day / every day** **is impacted** |
| **Impact on your child’s day to day life** |  |  |  |  |  |  |
| **Impact on your family’s day to day life** |  |  |  |  |  |  |
| **Impact on your child’s Education or access to education** |  |  |  |  |  |  |
| **Comments:**  |

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**End of form**

Now please return this completed for to the referrer, do not send directly to the assessment team.