**Supplementary information from supporting services (ASC99)**

**Autism Spectrum Disorder**

**Assessment Team (ASDAT)**

Community Paediatrics

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| **This form is to be** **completed by a someone working with the child, young person or family in a professional capacity and is someone who wishes to provide supporting information to the assessment process such as *SALT, EP, CAMHS worker, Family Support or Public Health Nurse.*** |

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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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| **Professional providing supporting information** |
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| **Name (Full)** |  |
| **Job Title** |  |
| **Agency / Organisation** |  |
| **Correspondence Address** |  | **Contact Numbers** |  |
| **Email Address** ***(Works only)*** |  |
| **In what capacity do you know this child / family?** |  |

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| **Please provide a summary of intervention / work you have undertaken with this child / family and the effectiveness of this.** |
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| **Please comment on Social Communication and Interaction** |
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| **Please comment on Self-Stimulatory Movements and Speech (STIMS)** |
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| **Please comment on Special Interests (SPINS) which pre-occupy their mind.** |
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| **Please comment on any sensory needs.** |
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| **What next:** Please return this completed form to the person co-ordinating the request for assessment. Please do not submit this form directly to the assessment team. |