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**Specialist Assessment Service**

**REFERRAL FORM**

**For**

***For consideration of a possible Pathological Demand Avoidance (PDA) profile of Autism Spectrum Disorder.***

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| This referral form is to be completed ***ONLY*** for young people who have ***previously been***  ***diagnosed with Autism Spectrum Disorder.*** |

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| 1. **Child/Young Person’s Details** | | | | | | | | | |
| Child/ Young Person’s first name/s: | | | Child/young person’s surname: | | | | | | |
| Date of Birth: | | | Age: | | | | | | |
| Sex assigned at birth: | | | Gender identity: | | | | | | |
| Child/young person’s Address:  Post Code: | | | Primary language:  Other languages spoken at home: | | | | | | |
| 1. **What nursery / school /college does the child/young person attend?** | | | | | | | | | |
| Name of School/Setting:  Address: | | | Telephone contact details of School/Setting;    Name of person at the setting that is the best person for us to speak to:  Current year group: | | | | | | |
| 1. **Parents/Carers details:** Please give full names and addresses (if different) of each parent/carer responsible for this child/young person where applicable | | | | | | | | | |
| Name: | | | Name: | | | | | | |
| Mother Father Carer (please circle ) | | | Mother Father Carer (please circle ) | | | | | | |
| Address:  Post code: | | | Address:  Post code: | | | | | | |
| Contact Telephone Number  Land line:  Mobile:  Can a message be left on these numbers? Yes/No | | | Contact Telephone Number  Land Line:  Mobile :  Can a message be left on these numbers? Yes/No | | | | | | |
| Is this child/young person looked after by the local authority Yes / No (Please circle ) | | | | | | | | | |
| Who holds parental responsibility for this child/young person? | | | | | | | | | |
| 1. **Referrer details*:*** *(We need to know who is referring this child/young person )* | | | | | | | | | |
| Name of person referring child/young person:  Address of person referring child/young person:  Post code: | | | | Please tell us who you are e.g. parent, SENCo, GP etc.  Telephone contact details: | | | | | |
| 1. **Date this form was completed:** | | | |  | | | | | |
| 1. **Details of the Child/Young Person’s GP:**   **(*Check with us if you are not sure if this is a Solihull GP)*** | | | | | | | | | |
| Name of the GP/Practice:  Address of GP Practice:  Post code: | | | | NHS number:  Telephone Number of GP: | | | | | |
| 1. **Details of agencies/professionals involved** | | | | | | | | | |
| Name of Agency: | Contact Name: | | | | | | | Tel No: | |
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| 1. **PARENT’S CONSENT** - In order for this referral to be considered, parents/carers or those with designated parental responsibility **MUST** give their signed consent. | | | | | | | | | |
| **Please read, sign, print name and tell us who you are in the boxes below:** | | | | | | ***Signature and date*** | | | ***PRINT NAME and tell us who you are in relation to this child/young person.*** |
| *I am aware of the concerns outlined in this referral and consent to the further assessment of my child/young person’s strengths and difficulties to be considered.* | | | | | |  | | |  |
| *I give my consent for further information to be requested from professionals currently or previously involved and if necessary, for this information to be discussed with the multi disciplinary team as part of the referral and assessment process.* | | | | | |  | | |  |
| 1. **Information about the child/young person** | | | | | | | | | |
| **Does this child/young person have any known physical or mental health conditions?** *(please include any allergies)*  **Describe the impact of these difficulties on the child/young person.**  **Is this child/young person currently on any medication? If so please detail:** | | | | | | | | | |
| Have they passed hearing checks? | | Yes No Don’t Know *( please circle)* | | | | | | | |
| Have they passed vision checks? | | Yes No Don’t Know *( please circle)* | | | | | | | |
| Does this child/young person wear glasses? | | Yes No Don’t Know *( please circle)* | | | | | | | |
| 1. **Child/young person’s family details** | | | | | | | | | |
| Tell us about key family members, and who lives in the house with this child/young person. | |  | | | | | | | |
| Do any other family members have any difficulties? | |  | | | | | | | |
| 1. **Social Care information** | | | | | | | | | |
| Is the child/young person or family currently supported by Social Care? | | Currently : Yes No Don’t know (please circle)  Previously : Yes No Don’t know (Please circle) | | | | | | | |
| Name and contact details of social worker if applicable | | Name:  Address:  Tel: | | | | | | | |
| Please tell us why this service is or was involved. | |  | | | | | | | |
| Is the child/young person aware of this referral? | | YES | | | | | NO | | |
| What are their views about their strengths, difficulties and this referral? (we understand that this is not always possible to comment on for very young children) | | | | | | | | | |
| 1. **Is there anything else that you would like to tell us about this child/young person to help us understand the complete picture? Continue on a separate sheet if necessary** | | | | | | | | | |
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| 1. **Signatures of people providing the information** | | | | | | | | | |
| ***Parents/Carers*** | | | | | ***Professional*** | | | | |
| Print name:  Signature:  Relationship to child:  Date: | | | | | Print name:  Signature:  Relationship to child:  Date: | | | | |

**Thank You!**

Please return to the Administration Team, The Specialist Assessment Service, Chelmsley Wood Primary Care Centre, Crabtree Drive, Birmingham, B37 5BU

***Please also include:***

‘Information from Parents/Carers – PDA’ form

‘Information from Professionals – PDA’ form (If applicable)