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**Specialist Assessment Service**

**REFERRAL FORM**

**For**

***Pathological Demand Avoidance (PDA)***

***also known as Extreme Demand Avoidance (EDA)***

This referral form is to be completed ***ONLY*** for young people who have ***previously been assessed by the Specialist Assessment Service and diagnosed with an Autism Spectrum Disorder.***

***If you wish to make a referral for a child who has not previously been assessed by the Specialist Assessment Service, or was previously assessed and did not receive an ASD diagnosis, you need to complete the general Specialist Assessment Service referral form and indicate on that form that you are requesting an assessment for a possible PDA.***

**Before you complete this form please check:-**

1. The referral has been discussed and agreed with parents/carers.
2. The child/young person is aged between 0 years and 17 years 11 months.
3. The child/young person is registered with a Solihull GP.
4. Already received a diagnosis of an Autism Spectrum Disorder and the profile of needs are indicating the need for assessment for PDA.

**Before this referral can be considered please ensure that the following things have been completed and paperwork attached:**

1. Information and evidence needs to be gathered and provided by key professionals in education in relation to:
   1. Observations of the child/young person
   2. Recommended strategies following observations implemented and outcomes documented; what has worked and what has not worked
   3. Implementation of strategies recommended to support a young person with a PDA and outcomes documented; evidence of effectiveness of such strategies (over a minimum period of two terms)
   4. Any changes that may have increased anxiety in a young person. If so information about support and strategies put in place and outcomes
   5. Any family/education circumstances that may potentially explain the complexities in presentation, e.g. significant changes, bereavements, ill health, life events resulting in stress in any family member

All of this information can be attached to and information provided in the Signs and Indicators form that we ask you to complete (please see point 2 below).

1. Completed the following forms and attached to this referral form:
   1. Signs & indicators of possible Pathological Demand Avoidance (PDA); Information from the ***Specialist Inclusion Support Service*** form
   2. Signs & indicators of possible Pathological Demand Avoidance (PDA); Information from Information from ***Parents and Carers*** form
   3. Signs and indicators of a possible Pathological Demand Avoidance (PDA); Information from ***professionals supporting the Child/Young Person*** form
   4. EDA Questionnaire from home
   5. EDA questionnaire completed by school
   6. EDA questionnaire completed by the SISS ASD Team
   7. EDA questionnaire completed by any other professional who is/has worked with the child/young person
2. Information is required from Solar (if they are involved in working with the child/young person) to ensure that the profile of difficulties cannot be explained by the ASD and additional anxiety disorder, or other mental health difficulty. They will need to provide:
   1. Signs and indicators of a possible Pathological Demand Avoidance (PDA); Information from professionals supporting the Child/Young Person form
   2. EDA questionnaire
   3. Copies of clinical letters and reports, as well as summary of involvement and impact

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| 1. **Child/Young Person’s Details** | | | | | | | | | | | |
| Child/ Young Person’s first name/s: | | | | | Child/young person’s family name: | | | | | | |
| Date of Birth: | | | | | Is the child/young person (please circle)  Male Female | | | | | | |
| Child/young person’s Address:  Post Code: | | | | | First Language spoken by this child/young person/family :  Interpreter needed? Yes/No | | | | | | |
| 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. R**eferrer 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. **Please tick as appropriate** | | | | | | | | | | | |
| White British | | |  | | | Bangladeshi or British Bangladeshi | | | | |  |
| White Irish | | |  | | | Other Asian Background | | | | |  |
| Other White Background | | |  | | | Caribbean | | | | |  |
| White & Black Caribbean | | |  | | | African | | | | |  |
| White & Black African | | |  | | | Other Black Background | | | | |  |
| White & Asian | | |  | | | Chinese | | | | |  |
| Other Mixed Background | | |  | | | Other Ethnic Group | | | | |  |
| Indian or British Indian | | |  | | | Ethnic Category Not Stated | | | | |  |
| Pakistani or British Pakistani | | |  | | |  | | | | |  |
| 1. **Information about the child/young person** | | | | | | | | | | | |
| **Does this child/young person have any known medical conditions, diagnoses or impairments?** *(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 | | | | Name:  Address:  Tel: | | | | | | | |
| Please tell us why this service is or was involved. | | | |  | | | | | | | |
| Is the child/young person aware of this referral?  *(we are aware that this may not be appropriate for young children)* | | | | YES | | | | NO | | | |
| What are their views about their strengths, difficulties this referral and possible further assessment and change in diagnostic outcome? (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** | | | | | | | | | | | |
| 1. **Signatures of people providing the information** | | | | | | | | | | | |
| ***Parents/Carers*** | | ***Professional (Children in school setting should be signed off by ASD lead/level 2 AET trained teacher)*** | | | | | | | | | |
| Print name:  ………………………………….  Signature:  …………………………………..  Relationship to child:  …………………………………..  Date: | | Print name:  ………………………………….  Signature:  …………………………………..  Relationship to child:  …………………………………..  Date: | | | | | | | | | |

Thank you for taking the time to complete the Specialist Assessment Service Referral Form.

The information provided will be considered by the Specialist Assessment Service Specialist Assessment PDA panel. We will then write to parents/carers to let them know the next steps for their child/young person and we will send copies of that letter to the key people involved with this child/young person.

Please send your completed referral form, along with any additional information to:

**Administrator**

**Specialist Assessment Service**

**Chlemsley Wood Primary Care Centre**

**Crabtree Drive**

**Birmingham**

**B37 5BU**

**Tel 0121 7228010 Fax 0121 424 5916**

**Please note we are unable to accept referrals electronically for reasons of data protection**