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**Specialist Assessment Service**

**REFERRAL FORM**

**Please refer to our website for guidance in completing this form;** [**https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/**](https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/The)

The Specialist Assessment Service works with children who have either complex medical and developmental needs or with children and young people where their difficulties may indicate an Autism Spectrum Disorder (ASD).

For children with complex needs we may also provide coordinated therapeutic work to meet a child’s needs. Service referral criteria are in place to ensure that this service works with the child/young people and their families who need and will benefit from further highly specialist assessment.

**The following checklist supports you to ensure that you are aware of all the information we require to consider a referral and make a decision whether a child/young person requires an Autism Assessment.**

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| **Before you send us this form for ASD referral please check the following access criteria:-** | **Tick/cross** |
| 1. The referral has been discussed and agreed with parents/carers/legal guardian (consent provided by someone with Parental Responsibility).
 |  |
| 1. The child/young person is registered with a Solihull GP.
 |  |
| 1. To refer for an Autism assessment the child must be aged 0 years and 17 years 11 months.
 |  |
| 1. If School/Nursery is involved then they have completed the professional section of the referral form.
 |  |
| 1. If other professionals are currently, or have been previously involved please include with this referral form copies of all reports/clinical letters regarding their input and advice, as well as their observations.
 |  |
| 1. Provide evidence that your child experiences significant difficulties across the 3 key areas of difference of their development associated with ASD – These are: Social interaction and communication, sensory needs and flexibility of thought and behaviour. To be accepted difficulties must be having an impact on their daily lives.
 |  |
| 1. There is evidence of a **graduated response** by professionals to meet a child’s individual needs. This needs to have been in place for a minimum of 6 months or 2 terms.

**Section 17 must be completed for children out of school or where there is significant difference in presentation between home & school.** There are further details on what graduated response means in **sections 14-17**  and you may also **refer to our website for further guidance on graduated response;** [**https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/**](https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/) |  |
| 1. The child/young person **does not** already have a diagnosis of ASD. We will also **not assess** a child/young person **who has had an assessment for ASD in the last two years.**
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**The following checklist supports you to ensure that you are aware of all the information we require to consider a referral and make a decision whether a child/young person requires a Complex Needs Assessment.**

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| **Before you send us this form for complex needs referral please check the following access criteria:-** | **Tick/cross** |
| 1. The referral has been discussed and agreed with parents/carers/legal guardian (consent provided by someone with Parental Responsibility).
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| 1. The child/young person is registered with a Solihull GP.
 |  |
| 1. To refer for a Complex Needs assessment the child must be aged under 5 years old
 |  |
| 1. Information to support the referral that details significant medical needs or difficulties which impact across all areas of a child’s development e.g. gross & fine motor, communication, sensory concerns, learning & play.
 |  |
| 1. Information to inform us that the child requires a highly specialist assessment and would benefit from specialist coordinated care packages to ensure their needs are best met.
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* This referral form is **NOT** to be used for a Dysphagia (Swallowing Difficulty) referral. The Specialist Assessment Service cannot accept responsibility for Dysphagia referrals on this paperwork. A separate Dysphagia Referral form exists which you will need to request from Community Therapies 0121 722 8010.

**If a referral form does not meet the access criteria for the team you have referred to the referral WILL NOT be accepted.**

Once a referral is submitted you will receive a response following completion of the referral screening process.

We require a wide range of detailed information to decide if this is the most appropriate service for a child or young person. The information provided forms part of the child/young person’s assessment if they are accepted.

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| **Why are you referring this child/young person** *Please tick appropriate box* |
| Specialist assessment of complex medical and/or developmental needs **(Complete sections 1- 13 and 26)**  |  |
| Specialist assessment of social communication difficulties including the possibility of an Autism Spectrum Disorder (ASD) **(Complete sections 1- 12 and sections 14 – 26)**  |  |

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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 Other If other please provide details of how they identify:   |
| 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 Email address:  | Contact Telephone Number Land Line: Mobile :Can a message be left on these numbers? Yes/No Email address:  |
| Is this child/young person looked after by the local authority Yes / No (Please circle )  |
| Who holds parental responsibility for this child/young person? See [www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility](http://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility) for a definition of parental responsibility if required.  |
| 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: Email address:  |
| 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. **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 |  |  |  |

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| 1. **Information about and previous involvement with our service**
 |
| **Has this child been referred for an Autism assessment previously? (If yes, when)****Has your child had an assessment for autism previously (If yes, give details of service/outcome)**  |
| 1. **Information about the child/young person**
 |
| **Does this child/young person have any known medical conditions or impairments?** *(e.g. learning disability, global delay, learning difficulty, ADHD, mental health diagnosis, physical condition) (please include any allergies)* **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/diagnoses?  |  |
| Please tell us of any significant life events that have occurred in the family |  |
| 1. **Social Care information**
 |
| Is the child/young person or family currently supported by Social Care or have been in the past?  | 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:Telephone:Email address:  |
| Please tell us why this service is or was involved.  |  |

**Please only complete this page if you are referring a child with complex medical and/or developmental needs. If you are referring a child/young person for an assessment of a possible ASD please DO NOT complete section 13 - move to section 14**

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| 1. **Complex medical/developmental needs referral information.**
 |
| What are parent’s current main concerns? | 1.2.3. |
| Describe any physical strengths or difficulties that this child has  |  |
| Describe any communication strengths or difficulties that this child has  |  |
| Describe any play and interaction strengths or difficulties that this child has  |  |
| Describe any learning strengths or difficulties  |  |
| Tell us anything else about this child that you feel would be helpful for us to know   |  |

**Please remember to enclose all the information you hold from other professionals and services. It will delay the referral being considered if they are not included.**

**END OF FORM for a Complex Needs referral**

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| 14.Graduated Response Evidence by professionals over two terms/6 months: **This must include areas of need we would typically associate with a possible Autism Spectrum Disorder (ASD), this includes needs with communication and social interaction, flexibility of thought and behaviour and sensory needs (3 key areas of difference).** **Tell us what are school/nursery/other professionals doing currently to support these needs? (above and beyond what is typical support for a child of this stage of development)** **Further details can be found at:** [**https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/**](https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/) **Please continue on a separate sheet if necessary:**  |

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| **Plan****Area of need identified (eg, communication, social interaction, sensory needs, transition support, emotional support, learning needs etc)** | **Start date of support** | **Do****Strategies used and who does it.****(please enclose any observations or checklists completed)**  | **Review****Describe the impact this support has had on the need identified** |
|  |  |  |  |
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| Does the child/young person have a Statement of Special Educational Need or an Education Health Care Plan in place? *YES?NO (please circle)*  |

**We would advise an observation is carried out using the School Observation Form which includes the 3 key areas of difference. This is available on our website. Three observations across a one month period is considered good practice.**

**This record sheet can be attached to this referral from as evidence to support an assessment. This form is available on our website at:** [**https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/**](https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/)

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| 1. **What are School/Nursery or other professionals main concerns at the moment?**
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| 1. **Tell us about any additional support this child/young person has previously received from professionals e.g. Health Visitor, Nursery, School, Solar, Specialist Teaching Services?**
 |
| **Describe the previous additional support**  | **Who was responsible for providing this support?** | **When did this assistance start and** **how often did it occur? End date?** | **What difference did it make?**  |
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| **17.Graduated Response Evidence at home over two terms/6 months for children out of school or where there is a significant difference in presentation at home and school:** **This must include areas of need we would typically associate with a possible Autism Spectrum Disorder (ASD), this includes needs with communication and social interaction, flexibility of thought and behaviour and sensory needs (3 key areas of difference).** **Tell us what you are doing currently over the past 6 months to support the identified needs you describe? (above and beyond what is typical support for a child of this stage of development)**  **Please continue on a separate sheet if necessary**: |
| **Area of need identified (eg, communication, social interaction, sensory needs, transition support, emotional support, learning needs)**  | **Describe current strategies being used at home to support your child associated with the need.**  |
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| **18.What are parents/carers main concerns at the moment** |
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| 1. **Child/young person’s views**
 |
| 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 and any difficulties they may be experiencing? (we understand that this is not always possible to comment on for very young children)For older children we require their consent to participate in the assessment process.  |
| **Current strengths and difficulties**  | **This column to be completed by Parents/carers**  | **This column to be completed by a key professional involved e.g. SENCO, ASD lead.**  |
| 1. **Social Communication and Interaction skills**
 |
| **Social Emotional Reciprocity** |
| Describe whether/how this child/young person starts interactions with peers and adults in social situations?  |  |  |
| Do they show and/or talk to others about their interests and achievements to share these? Describe how they approach this |  |  |
| Describe how this child/young person holds a two way interaction/conversation. Consider the below;* Take turns in play/conversation, dominate or get left out?
* Respond to their name being called or when being spoken to.
* Initiate interaction by showing, bringing, pointing to things.
* Initiate a conversation with others to show social interest.
* Keep on topic or go off on tangents (change topic randomly).
* Awareness of listeners needs
* Show interest in what people are saying/doing
* Talks to peers and adults alike
 |  |  |
| Describe how this child/young person expresses themselves and is it in a way that is appropriate to their age group? Would you know if they needed help/support? If so – how would this be communicated? |  |  |
| How does the child/young person manage or share their own emotions with others? * Do they talk about and show understanding of their own feelings?
* Do they need more support than you would expect to manage their emotions?
* Do they share their enjoyment, achievements with others?
* Do they express pleasure in social situations?
* Do they enjoy being praised?
 |  |  |
| **Non-Verbal Communication**  |
| Describe the child’s use of;* Eye contact
* Facial expression
* Gesture (movement of hands/head to communicate e.g. nod, size or movement of something)
* Body Posture (e.g. closed/open, rigid/changeable)
 |  |  |
| Describe the child/young persons ability to understand other people’s facial expressions, gesture, body language |  |  |
| Is there anything unusual about the child/young person’s speech?Consider:* Variation in tone of voice
* Too fast/slow
* Too loud/quiet
* Rhythm and rate
 |  |  |
| **Social Awareness and Understanding**  |
| Do they now or did they when younger engage in imaginative play with peers? E.g. sharing ideas, role playing |  |  |
| Has the child/young person developed and maintained close friendships?  |  |  |
| How does the child/young person manage these relationships?* How do they play/spend time with others?
* Do they share interests and activities with their friends, both of their choice and of friend’s choice?
* Do they share in positive emotions with friends e.g. celebrate others successes/birthday?
* Do they show empathy and support for friends/others when needed?
* Can they understand the views/opinions of others?
* Do they show remorse when they have done something wrong to others? Can they repair when a situation goes wrong?
 |  |  |
| Can they adjust their behaviour appropriately, showing an understanding of what is expected of them, in different situations?  |  |  |
| 1. **Flexibility of thought and behaviour skills**
 |
| **Repetitive speech or movements or object use** |
| Describe any unusual vocalisations or repetitive manners of speech e.g.- Repetitive guttural sounds, unusual squealing,  repetitive humming- Use of formal/adult speech, Immediate or  delayed repetition of words/phrases, - Scripted/learned phrases, made up words.  |  |  |
| Describe any unusual or repetitive motor movements e.g. finger flapping or twisting or general body movements, rocking, spinning, jumping, pacing, tip toe walking.  |  |  |
| Describe any unusual or repetitive play/use of objects * e.g Lines up toys or objects
* Repetitively opens and closes doors
 |  |  |
| **Routines, rituals or excessive resistance to change** |
| Describe how this child/young person copes with any changes to their routine and what you may have to do to help them cope. |  |  |
| Describe how the child/young person copes with transition from one activity to another/one situation to the next |  |  |
| Describe any unusual routines that this child/young person may have for e.g. walking to school exact same route, needing specific sequence for bedtime routine to manage.  |  |  |
| Do they engage in any unusual rituals?e.g. Repetitive questioning about a particular topic, say things in a specific way or expect others to say things a specific way, do they engage in any compulsive behaviours.  |  |  |
| Tell us about any rigid patterns of thought;* Literal thinking – can they understand sarcasm, hints, sayings e.g it’s raining cats and dogs?
* Can they understand humour? What makes them laugh?
* Fixed on rules
 |  |  |
| **Approach to Interests/activities** |
| What does the child/young person enjoy doing/have interest in and how do they approach their interests? What is the impact of daily life?- any unusual interests- obsessive interests- Preoccupations - Limited range of interests  |  |  |
| How do they cope with a perceived sense of failure?  |  |  |
| Do they have any unusual fears?  |  |  |
| **Sensory Information**  |
| Describe if this child/young person is extra sensitive e.g. to noises, textures, touch, smell, movement. |  |  |
| Does this child/young person seek additional sensation? If so, how? E.g. do they fidget, fiddle, touch, can't sit still?  |  |  |
| 1. **Physical Skills**
 |
| Describe any strengths or difficulties with gross motor skills, balance or co-ordination.  |  |  |
| Describe any strengths or difficulties with fine motor skills e.g. handwriting, keyboard skills, drawing, painting, cutting.  |  |  |
| 1. **Independence in Daily Living Skills**
 |
| Describe if this child/young person can complete daily living skills as expected for their age? * Toileting
* Dressing
* Eating
* Drinking
* Sleep
* Attend to their own personal hygiene needs
 |  |  |
| 1. **Adaptive Skills**
 |
| Describe the child/young person’s general mood and behaviour;Can they manage/regulate their emotional responses*?* |  |  |
| Has the child/young person expressed possible self harm or harm towards others? |  |  |
| 1. **Cognition and Learning**
 |
| Is the child meeting age related expectations in school? |  |  |
| Can this child/young person maintain their attention in a way appropriate to their age group? |  |  |
| Describe any observed barriers to learning |  |  |
| Do they have any particular strengths/difficulties in different subject areas? |  |  |
| Give details regarding the child’s attendance levels in school. |  |  |
| ***Remember to include information from school or from other professionals that you have involved. For parents/carers the school SENCo should be able to help you with this as it will be in your child/young person’s school records.***  |
| 1. **Signatures**
 | ***Parents/Carers*** | ***Professional*** |
|  | 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 at the Assessment panel. This is held fortnightly. 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 remember if this child/young person does not have a Solihull GP, information is missing or if evidence does not go back over 6 months (or 2 terms) for children being referred for an ASD assessment, we are not able to accept a child/young person’s referral.

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

**Specialist Assessment Service**, **Administrator, Chelmsley Wood Primary Care Centre, Crabtree Drive, Birmingham**

**B37 5BU**.

**Tel 0121-722-8010**

 **Service Clinical Lead: Claire Howell**