Children's Autism and ADHD Assessment Service

Children and Young Peoples Services Referral Form

*To be completed by any Health, Education or Social Care professional who knows the child well. Autism assessments will be considered for all children up to the age of 17 years 11 months. ADHD assessments will be considered for children between the age of 6 – 17yrs 11 months.

*For referrals to be eligible for review by the Children's Autism and ADHD Assessment Service for consideration of assessment of Autism and/or ADHD, the following information must be included alongside this referral form:

1. Family Information Form, completed by Parents/Guardian
2. School/Teacher Reports (if the young person is in an Educational Setting)
3. The child must be on a My Plan+ (or equivalent) or have an EHCP in place

Evidence of two review cycles of the child's plan must have taken place. This may be two reviews of a My Plan with evidence that the child has then moved to a My Plan+ (or equivalent) or two reviews of a My Plan+ (or equivalent). If the child has an EHCP in place, evidence of this should be provided.

*Please complete details of all adults with parental responsibility

Documents must be in one of the following formats: Word document, pdf, or jpeg.

Date of referral:		**Name of referrer:**	
Role:			
Address of referrer:			
Telephone Number:			

Details of person being referred					
Surname:		**First name:**		**D.O.B**	
Address:		**Parent or Carer Name & Address:**			
		Relationship:			
		Telephone Number:			
		Mobile Number:			
		Ethnicity:			
GP Name:		**GP Surgery & Address:**			
GP Tel No:		**GP Email Address:**			
NHS Number:		**Lives with:**		**Parental Responsibility:**	
Child in Care:		**Stage of graduated pathway (My Plan, My Plan+ or EHCP):**		**Parent/Carer aware of referral:**	
Yes ☐ No ☐				Yes ☐ No ☐	
Education Placement details: *If the child is not in full time education, please detail below if the family is accessing any of the following services:*					

- *Not in Education, Employment or Training (NEET) Services, through the Gloucestershire Youth Support Team (young people aged 16-18)*
- *Special Education Needs and Disabilities Advice and Support Service (SENDIASS)*
- *Team Around the Locality Cluster (TALC)*
- *Are there any other clubs that your child attends?*

Current Diagnosis Information:	**Current Medication:**

Reason for Referral:

Is this request for *(please tick the relevant boxes)***:**

ADHD Assessment	☐	Autism Assessment	☐

Strengths of Child:

Needs of Child or Challenges they experience:

Please describe the impact of these needs on the child (e.g. relationships with others, attainments, emotional wellbeing)

Support currently in place:

Inc. support the family have from professionals and family in addition to funded support.

List the steps taken/service input taken to date (give evidence of universal, targeted, and specialist services). What was the outcome of this input?

Any Safeguarding concerns?

Have the family every been known to social care or Early Help. Have the family ever had an allocated family support worker? Has the child ever been on a child in need or child protection plan? Have you had any worries about the family environment or home?

Risk Information: *Including harm to self or others and behaviours which may need extra support. Has there ever been support from the youth support team?*

Has parent consented to referral and consented for information to be collected from school about the child/young person (for children under 16)?	Yes ☐ No ☐

Unfortunately, we will not be able to accept the referral if parental consent has not been given.

Parental thoughts and hopes: *What are they worried about for their child and what would they like from the assessment?*

Has the child given informed consent to be referred to the Children's Autism and ADHD Assessment Service (if they are over 16 or younger with competence)?	Yes ☐ No ☐
Has the child given consent for school to complete a report of them (if they are over 16)?	Yes ☐ No ☐

Where appropriate we would encourage you to ensure the child is aware that they have been referred for consideration of assessment of Autism and/or ADHD. This is especially important for children over 10.
Please tell us the child's thoughts and hopes
What does the child think of the referral?
Expected Goals of referral to Children's Autism and ADHD Assessment Service:

I can confirm that the pre-referral process has been followed and that all the professionals who know the child have met to discuss their needs and have agreed a plan to support them.	Yes ☐ No ☐
Date of Meeting:	
Signed:	

Referral Details
Please send completed referral by email: SCAASNeuroReferrals@ghc.nhs.uk