NHS
Somerset
NHS Foundation Trust

Somerset Autism Spectrum Service

Glanville House, Church Street, Bridgwater, Somerset, TA6 5AT

Tel: 01278 720266. Email: SomersetAutismSpectrumService@SomersetFT.nhs.uk

REFERRAL FORM

GUIDANCE NOTES FOR MAKING A REFERRAL

Please read the following information before making a referral for a diagnostic assessment for Autism Spectrum Disorder. If you would like to discuss your referral prior to sending, please contact us.

This referral form is in two parts. Part 1 is to be completed by the referring professional. Part 2 is to be completed by the person being referred.

Both parts must be completed and returned at the same time.

When a referral is received, members of the Somerset Autism Spectrum Service will discuss it to decide whether an assessment is necessary and beneficial at this time. Please provide as much detail as you can, including specific examples.

Somerset Autism Spectrum Service is primarily a diagnostic service. As a service we are unable to provide case management / care co-ordination and/or oversee / manage risk during this process or while someone is awaiting assessment. It is expected that the GP (and/or referrer/care coordinator) would hold the overview of risk and should be contacted if there are concerns. We will of course liaise with professionals as appropriate.

We are only able to accept referrals that meet the following criteria:

- Aged 18 years and above
- Registered to a G.P. in Somerset
- Presentation and experience is indicative of Autism Spectrum Disorder and shows evidence of a clinically significant impairment in functioning as outlined in the DSM-5 Diagnostic Criteria at the end of this form.
- No existing diagnosis of learning disability (as we are not commissioned to provide a diagnostic service for people with a learning disability)

Referrals can be posted or emailed to us via the above contact details.

If you have difficulty completing the referral form, please get in touch.

PART 1 – REFERRER TO COMPLETE

PATIENT DETAILS			
Name:		**Date Of Birth:**	
Preferred Name: (if different)		**NHS Number and/or Rio Number**	
Full Address Including Postcode:		**Home Telephone Number and/or Mobile Number:**	
Date Started Living At This Address:		**Email Address:**	
Sex Assigned At Birth:		**Current Gender Identity & Preferred Pronouns**	

Ethnicity:	White British	☐	White Irish	☐	White any other background	☐	Mixed – White/Black Caribbean	☐
	Mixed White/Black African	☐	Mixed White Asian	☐	Mixed any other background	☐	Asian / Asian British - Indian	☐
	Asian / Asian British – Pakistani	☐	Asian / Asian British – Bangladeshi	☐	Asian / Asian British – other	☐	Black / Black British - Caribbean	☐
	Black / Black British – African	☐	Black / Black British – other	☐	Chinese	☐	Any other ethnic group	☐

REFERRER DETAILS			
Referrer Name:		**Job Title:**	
Workplace Address Including Postcode:		**Telephone Number:**	
Date Of Referral:		**Email Address:**	

GP DETAILS (If not referrer)			
GP Name:		**Surgery Name:**	
Surgery Address Including Postcode:		**Telephone Number:**	
Date First Registered at Surgery:		**Email Address:**	

RISK CHECKLIST			
Please tick if there are any of the following risks:	**Yes**	**No**	**Unsure**
Self-harm	☐	☐	☐
Self-neglect	☐	☐	☐
Exploitation	☐	☐	☐
Suicide	☐	☐	☐
Violence/harm to others	☐	☐	☐
Risk to children	☐	☐	☐
Any reason why a home visit or lone working would be inappropriate	☐	☐	☐

If you have answered yes to any of the above concerns, please explain below.

Relevant Medical/Mental Health/Neurodevelopmental History:

ARE YOU REQUESTING A DIAGNOSTIC ASSESSMENT OR POST DIAGNOSTIC SUPPORT	**DIAGNOSTIC ASSESSMENT**	**POST DIAGNOSTIC SUPPORT**
	☐	☐
Has the person being referred consented to this referral?	☐ **Yes**	☐ **No**

WHAT HAS PROMPTED THIS REFERRAL:

PART 2a – PERSON BEING REFERRED TO COMPLETE

A diagnostic assessment for Autism Spectrum Disorder explores your experience of social interaction and communication, as well as behaviours, interests, routines and sensation. We are looking for information about the challenges you face and the differences you experience.

To help us to decide whether an assessment is relevant and beneficial at this time, please provide us with as much information about these areas as possible. Try to provide specific, real life examples where you can.

If you need help to fill in the referral form, please contact us.

Please tell us if you have any other neurodevelopmental conditions *i.e., ADHD, Dyslexia, Dyspraxia, Dyscalculia, Dysgraphia, Tourette's Syndrome* **(including whether you have previously received a formal Autism Diagnostic Assessment. If you have, please provide details):**

Please tell us about any concerns related to a**ttention, hyperactivity and impulse control** (attention and concentration / focus on task / hyperactivity, fidgeting, frequent body movements / forgetfulness / daydreaming / emotional dis-regulation / lack of sense of danger / organisational skills / peer relationships / oppositional behaviour):

If you are currently employed or a student, what is your role/course?

How would you prefer to be contacted? Phone ☐ / Email ☐ / Post ☐ / Text Message ☐

Please describe issues that may affect accessibility if you commence with the assessment process (i.e. hearing or visual impairments, physical disability, communication needs, sensory sensitivities)

If you already have an Autism diagnosis and are seeking **post diagnostic support**, please go on to **PART 2b.**

<u>Describe your experiences of difficulties with social interaction/communication. Please give specific examples unique to you.</u>
It may be helpful to consider the following aspects: • Difficulties forming, maintaining, and understanding social relationships. • Verbal and non-verbal communication. • Difficulties noticing, understanding, and expressing emotion. • How important it is for others to know how you are feeling. • Other people's observations about the way you communicate.

Describe your experiences of any restricted, repetitive patterns of behaviour, interests, or activities. Please give specific examples unique to you.

It may help to consider the following aspects:

- Body mannerisms
- Unusually inflexible routines
- Rigidity of thoughts or behaviour
- Significant difficulty with change
- Narrow/intense interests
- Sensory hyper/hyposensitivities

Describe how the differences mentioned above impact your day-to-day life. Please give specific examples unique to you.

It may help to consider the following aspects:

- Education and/or employment
- Managing domestic chores and self-care
- Friendships and relationships
- Mental and/or physical health issues

Thinking about the differences you have mentioned above, please tell us how these may have affected you in childhood.
i.e., language development, developmental milestones, social difficulties, behavioural concerns, education.

Please describe any particular strengths, skills or abilities that you have.

Is there anything else you would like to add to your referral form? This could include a statement from somebody that matters to you.

PART 2b – PERSON BEING REFERRED TO COMPLETE
Post Diagnostic Support

Date of Autism Assessment:	
Who made the diagnosis?	
Diagnostic report available?	Yes☐ No☐ If no, please explain why:
Please note, we require evidence of a formal Autism diagnostic report for post-diagnostic support. ***Please forward copies of the report or any other paperwork pertaining to this diagnosis.***	

Please describe your current difficulties and the post-diagnostic support you are seeking:
i.e., housing, benefits, employment, social care, education, mental health

Please Return the Completed Referral Form (Part 1, and Part 2a or 2b) to Somerset Autism Spectrum Service

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