**ADULT REFERRAL FOR A DIAGNOSTIC ASSESSMENT OF AUTISM**

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| **Service users details**  |
| Name: | Title: | DOB: |  |
| Preferred name: |  |  |  |
| Address: |  | NHS number: |  |
| PARIS number: |  |
| Email: |  | Phone: |  |
| Preferred language: | Ethnicity: | Gender: |
| **Referrer details**  |
| Name: | Date of referral: |
| Address: | Profession: |
| Phone:  |
| Email address : |
| Have you discussed the referral with the person? Y □ N □ Please note, referrals will not be accepted without informed consent. Please advise the client that the IAS are a multi-agency team so information may be accessed by both local authority and health staff. |
| **GP details (if not referrer):** |
| Name :  |  | Phone: |  |
| Address : |  | Email address : |  |
| **Other Professional’s involved:** |
|  | Name | Service | Contact details |
| 1  |  |  |  |
| 2 |  |  |  |
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| **Developmental history:**  |
| *(e.g., delays in meeting development milestones such as speech; loss of skills they had acquired; unusual behaviour in childhood; differences in interaction and communication; additional educational needs etc.?)* |
| **Social interaction:** |
| *(e.g., does the person have difficulties: making and/or maintaining relationships; understanding and managing emotions; understanding other people’s emotions; understanding social rules etc.?)* |
| **Social Communication:**  |
| *(e.g., does the person have: difficulties in reciprocal communication; unusual speech; repetitive speech; unusual eye contact; reduced facial expression or gesturing; flat intonation; problems in understanding such as taking things literally?)* |
| **Repetitive/restricted behaviours:** |
| *(E.g. does the person have: highly focused all-encompassing interests; excessive adherences to routines that are unusual; resistance to change; inflexible thinking; repetitive behaviour or rituals; strong adherence to rules; repetitive or stereotyped movements etc.?)* |
| **Sensory differences:** |
| *(Does the person seem to have significant differences in their sensory processing? E.g., not noticing pain; noticing sounds, smells, tastes, or visual details that others do not; difficulties with food due to textures or taste sensitivities; avoiding touch; different temperature regulation; getting distressed with too much sensory stimuli; etc)* |
| **Has the person had or experiences any of the following:**  |
| Problems in obtaining or sustaining education or employment? |  |
| Difficulties in initiating or sustaining social relationships? |  |
| Previous or current contact with mental health or learning disability services.Does the person have another diagnosis? |  |
| **Please specify any further documentation enclosed with this referral for further information:** |
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| **Please comment on any relevant issues relating to risk?** |
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| **Additional information inc specific requirements when accessing services:**  |
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