**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 |
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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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