**SOCIAL COMMUNICATION & AUTISM SPECTRUM SERVICE**

**REFERRAL / INFORMATION FORM**

(Please use **BLOCK CAPITALS**. Please complete all the requested details.)

Thank you for referring to our service. In order to ascertain if we are the best service to meet this child's needs, we would be grateful if you could complete this referral / information form for us and return to: Lydia Kyei, Neurodisability, Level 10 Frontage, Great Ormond Street Hospital, Great Ormond Street, London, WC1N 1EH. **If we have not received this form back within three weeks, we will assume you do not wish to proceed with this referral and will write to close the referral with us.**

**SCASS Referral Criteria:**

* **Aged from 4-17 years;**
* **Under the care of local CAMHS /EWMHS or local paediatric service, and referral made / supported by one of these teams;**
* **Formally assessed locally for ASD and where diagnostic clarification is required OR referred person has high level of complexity / potential comorbidities such that MDT tertiary assessment is needed;**
* **Local clinical team will be required to hold care co-ordination responsibilities - any identified risk will need to be supported and managed locally;**
* **Child does not have diagnosed Intellectual Disability.**

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| **Details of the child referred**  |
| **FORENAME(S):** **SURNAME:****Preferred Name:** **Address:****Postcode:** | **Male / Female:****Date of Birth:****NHS No:****Home Telephone:** **Language / Communication Needs** - Is translator / interpreter needed? If so, which language? |
| **Name(s) of Parent / Carer(s) who live with referred child:** **Mobile Telephone number(s):** | **Relationship(s) to Referred Child:****Which of these parent / carer(s) have parental responsibility?** |
| **Are there additional parents who do not live with the child but have parental responsibility? Yes No** **If Yes:** Should the SCASS send second copies of correspondence to this parent?  **Yes No****OR** will the parent above be responsible for passing on information about the assessment? **Yes No** **Additional Parent's Name: Relationship to Referred Child:** **Address:****Home Telephone Number: Mobile Telephone Number:** |
| **Child's GP Name:****GP Address:** | **Telephone Number:** |
| **Referrer Details** |
| **Name:****Designation:****Date of referral:****Signature:** | **Address:****Telephone Number:****Email:** |

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| **Details of Current Services / professional involvement:** e.g. other NHS providers, social care, private healthcare, probation, education services |
| **Name** | **Designation** | **Service** | **Telephone Number** |
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| **Details of Previous Assessments** |
| **ASD Assessments:**ADOS-2 ADI-R3DiOther Detailed ASD Developmental HistorySchool Observation Other (Please Specify):**PLEASE ATTACH ALL PREVIOUS REPORTS** | **Other Relevant Assessments:** (Please specify - e.g. Educational Psychology, Cognitive Assessment, School, CAMHS, Social Care, SaLT, Occupational Therapy)**PLEASE ATTACH ALL PREVIOUS REPORTS** |
| **Referral Details** |
| **Reason for referral and current concerns:** Please include any social communication concerns that have led to this referral |
| **Describe any current risks and what is keeping the person safe:** |
| **Please state any existing diagnosis:** |
| **Medication:** |
| **Please state any additional important information that would be helpful for us to know and that has not been mentioned above:**  E.g. learning or speech and language needs, mental health concerns, any important family information (such as stresses, difficult experiences, family conflict) that it would be important for us to know about? |