**NEURODEVELOPMENTAL ASSESSMENT CLINIC (NAC)**

**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 and return it to:

**Wolfson Neurodisability Service  
Level 10 Main Nurses Home  
Great Ormond Street Hospital  
Great Ormond Street  
London  
WC1N 3JH**

**Email:**[**gos-tr.neurodisabilityreferrals@nhs.net**](mailto:gos-tr.neurodisabilityreferrals@nhs.net)

The referral must be accompanied by reports/assessments that have been carried out locally.

**Referral Criteria:**

Referrals are only accepted from Community Paediatric or CAMHS services, who have undertaken initial assessments of the child’s developmental or behavioural concerns and should be accompanied by previous reports to inform the team of which assessments have been completed and what support has been offered. All children must have a named Consultant Paediatrician or Consultant Child and Adolescent Psychiatrist. Referral to our service must not be associated with closure of the case by local paediatricians or CAMHS services. Referrals should remain open to the referring team.

* Children and young people with known intellectual disability, sensory impairment or complex medical conditions including syndromes, genetic anomalies, stable epilepsy and cerebral malformations where the medical condition creates diagnostic uncertainty or where the local team require additional assessments to understand the child’s needs.
* Children and young people up to the age of 18 years.
* The local clinical team will be required to hold care co-ordination responsibilities - any identified risk will need to be supported and managed locally.

Exclusions

* Unfortunately GP referrals or self-referrals are not appropriate for this clinic. We would advise GPs to refer to local Community Paediatric on CAMHS services first, to ensure local support and understanding
* For children referred internally (from other departments within Great Ormond Street) or from Consultant Paediatricians we will always liaise with their local Community Child Development team or CAMHS to ask for their agreement, and clinical questions, before arranging to see the child. It may be more appropriate for the local team to carry out further assessment initially
* We are unable to accept referrals for initial diagnostic assessments for ASD/ADHD where the primary reason for referral is to expedite diagnosis because local teams are unable to meet capacity/ long waiting times locally
* For children in mainstream education where ASD is suspected the referral may be passed on to the Social Communication & Autism Spectrum Clinic at GOSH CAMHS.

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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 NAC 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 Previous Assessments** | |
| **ASD Assessments:**  ADOS-2  ADI-R  3Di  Other Detailed ASD Developmental History  School 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? | |

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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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