## Social Communication and Autism Assessment Service

## Children and Young Peoples Services REFERRAL FORM

**To be completed by any professional**

**For referrals to be accepted please include the Parent Information Form, Nursery/School, and either or all MyPlan, Myplan +, My Assessment, ECHP, Or minutes of professional meeting.**

**All documents must be in one of the following formats; Word document, pdf or jpeg.**

|  |  |
| --- | --- |
| **Date of referral:** | **Name of referrer:** |
| **Role:** | |
| **Address of referrer:**  **Telephone Number:** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of person being referred:** | | | |
| **Surname:** | **First name:** | | **D.O.B** / / |
| **ETHNICITY** |  | | |
| **Address:** | | **GP Name**  **GP Surgery**  **GP Telephone Number**  **GP Email address** | |
| **Parent or Carer Name:**  **Address**  **Relationship:**  **Telephone Number:**  **Mobile Number:**  **Email address:** | | **Parent or Carer Name:**  **Address:**  **Relationship:**  **Telephone Number:**  **Mobile Number:**  **Email Address:** | |
| **NHS Number:** | **Lives with:** | | **Parental Responsibility:** |
| **Child in Care:** | **Stage of graduated pathway** | | **Parent/Carer aware of referral:**  **Yes / No** |
| **Education Placement details:** | | | |
| **Details of how the family would like to be contacted (email/ letter)** | | | |

|  |  |
| --- | --- |
| **Current Diagnosis Information:** | **Current Medication:** |
|  |  |

|  |
| --- |
| **Reason for referral** |
| **Strengths of Child** |
| **Needs of Child or Challenges they experience** |
| **Support currently in place:** Inc support the family have from professionals and family in addition to funded support. Tell us about what support has been tried in the past and who has been involved. |
| **Any Safeguarding concerns?** Have the family every been known to social care or Early Help. Have you had any worries about the family environment or home? |
| **Current Risk Information:** Inc harm to self or others and behaviours which may need extra support. |
| **Has parent consented to referral? YES / NO**  **Unfortunately, we will not be able to accept the referral if parental consent has not been given.**  **Parental thoughts and hopes:** What are they worried about for their child and what would they like from the assessment |
| **Child’s thoughts and hopes:** What does the child think about the referral? |
| **Expected Goals of referral to Social communication and Autism Assessment Service:** |

I can confirm that the pre-referral process has been followed and that all the professionals who know the child have met to discuss their needs and have agreed a plan to support them.

Yes No

Signed: ………………………………………………..

