

<u>REFERRER INFORMATION</u>	
Name	Profession/Service
Address	Telephone number
	e-mail

<u>GP INFORMATION (IF DIFFERENT FROM ABOVE)</u>	
Name	Telephone number
Address	e-mail

<u>PATIENT INFORMATION</u>		
Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity
Date of birth	Hospital number	
Address	Telephone number	
	Postcode	
Occupation		
Is the patient aware that this referral has been made		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient aware of why this referral has been made		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient consented to this referral being made		<input type="checkbox"/> Yes <input type="checkbox"/> No

DETAILS OF INFORMANT FROM WHOM DEVELOPMENTAL HISTORY / ADDITIONAL INFORMATION MAY BE SOUGHT (For confirmation of an ICD-10 diagnosis, a developmental history is required.)		
Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity
Address	Telephone number	
	Postcode	
Relationship to patient		

FUNDING	
Has funding been secured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES please give details	
Name	Telephone number
Address	

REASON FOR REFERRAL	
Please give brief details of presenting concerns	
Approximate duration of presenting concerns	
Is there reported/evidence of impairment of social interaction/communication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there reported/evidence of rigid or repetitive activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there reported/evidence of behavioural disturbance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a history of any acquired brain injury/ neurological trauma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES did the patient's current difficulties pre- or post-date this?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any other known medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES please give brief details	
Are there any other known co-morbid psychiatric conditions (e.g. schizophrenia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES please give brief details	
Does the patient already have a provisional/confirmed Autistic Spectrum Disorder diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current medication (Please list)	

PREVIOUS CONTACT WITH RELEVANT SPECIALIST SERVICES

Genetics?  Yes  No Are results available?  Yes  No

Contact details of clinician

Neurology?  Yes  No Are results available?  Yes  No

Contact details of clinician

Neuropsychology?  Yes  No Are results available?  Yes  No

Contact details of clinician

Psychiatry?  Yes  No Are results available?  Yes  No

Contact details of clinician

ASSESSMENT OF RISK

It is important to know whether there are any factors that may put our clinicians, the patient or others at risk.

Are there any known forensic issues, i.e. convictions?  Yes  No

If YES please state what for

Are there any other known risk factors (e.g. history of violence, sexually inappropriate behaviour?)  Yes  No

ADDITIONAL INFORMATION

Before the patient attends for an appointment he/she will be asked to complete a number of questionnaires.

Does the patient have difficulty with any of the following:

Reading or comprehension (e.g. dyslexia)?  Yes  No

Hearing?  Yes  No Vision?  Yes  No

Fine motor skills?  Yes  No Mobility?  Yes  No

A clinic assessment will take a full day - would the patient be able to attend?  Yes  No

Is there someone who will be able to accompany the patient to the Clinic to provide a developmental history?  Yes  No