

## Hampshire and IOW ASD Service

Psicon accept new referrals for Children and Young People (CYP) **aged 3y 0m – 17y 364 days** for Autism Spectrum Disorder (ASD) assessment.

Exclusion Criteria:

- CYP who present with co-morbid mental health difficulties and/or risk to self/others
- CYP with a moderate to severe learning disability

If you suspect any co-morbid mental health presentation or risk in this case, **please instead refer to CAMHS** who will consider assessing for ASD if their mental health needs meet threshold or refer onto Psicon if not.

CYP must be registered at a GP practice in the following areas:

- North East Hampshire
  - North & Mid Hampshire
  - South West Hampshire
- South East Hampshire
  - Isle of Wight

Please note we do not accept referrals for CYP registered at a GP practice in **Farnham, Southampton, or Portsmouth**.

For this service, please email this referral form (along with any other supporting documentation) to:

[kmccg.psicon.childrens@nhs.net](mailto:kmccg.psicon.childrens@nhs.net)

Once Psicon receive the referral, parent/guardian will be invited to carry out the screening process to determine whether the CYP meets the threshold for a full assessment.

### 1. CYP DETAILS

<b>CYP Name:</b>		
<b>NHS Number:</b>		
<b>Date of Birth:</b>		
<b>Gender:</b>		
<b>Ethnicity:</b>		
<b>Full Address:</b>		
<b>Is the CYP: (please tick all that apply)</b>	<input type="checkbox"/> Looked after Child/LAC (by local authority) <input type="checkbox"/> Adopted <input type="checkbox"/> Under a special guardianship order <input type="checkbox"/> Not in education/home-schooled <input type="checkbox"/> Subject to a Child Protection Plan <input type="checkbox"/> Military Family	

### 2. PARENT/GUARDIAN DETAILS

<b>Parent/Guardian Name:</b>	
<b>Relationship to CYP:</b>	
<b>Full Address: (if different from above)</b>	
<b>Home Number:</b>	
<b>Mobile Number:</b>	
<b>Contact Email:</b>	
<b>Please list names of all parties with parental responsibility and their relationship to the CYP:</b>	

**3. REFERRER DETAILS** (if referrer is GP, please complete section below)

<b>Name:</b>	
<b>Job Title:</b>	
<b>Referral Source:</b>	<input type="checkbox"/> GP <input type="checkbox"/> CAMHS <input type="checkbox"/> Paediatric service <input type="checkbox"/> Social Worker <input type="checkbox"/> School
<b>Address:</b>	
<b>Telephone Number:</b>	
<b>Contact Email:</b>	

**4. GP DETAILS**

<b>GP Name:</b>	
<b>GP Surgery Name:</b>	Tadley Medical Partnership
<b>GP Surgery Address:</b>	Tadley Medical Partnership, Holmwood Health Centre, Franklin Avenue, Tadley, RG26 4ER
<b>Telephone Number:</b>	0118 981 4166
<b>Contact Email:</b>	<a href="mailto:holmwoodhealthcentre@nhs.net">holmwoodhealthcentre@nhs.net</a>

**5. PLEASE COMPLETE FOR ALL ASD ASSESSMENT REFERRALS**

<b>a) Language and conversation</b>	<input type="checkbox"/> Uses full sentences correctly <input type="checkbox"/> Speaks in simple phrases (e.g., a 3-word sentence that is not repeating what you have already said) <input type="checkbox"/> Speaks in single words <input type="checkbox"/> Does not communicate verbally/selectively mute
<b>b) Does the CYP report having any sensory sensitivities?</b>	<input type="checkbox"/> None <input type="checkbox"/> Smell <input type="checkbox"/> Taste <input type="checkbox"/> Light <input type="checkbox"/> Textures <input type="checkbox"/> Sounds  If yes, please detail:
<b>c) In addition to yourself, has any other professional ever suggested the patient might have ASD?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, please detail:
<b>d) Does the CYP show significant signs of the following? (Please select all that apply)</b>	
<input type="checkbox"/> Difficulties with forming and/or maintaining friendships with their peers <input type="checkbox"/> Difficulties with verbal communication <input type="checkbox"/> Difficulties with non-verbal communication (e.g., eye contact, appropriate facial expressions) <input type="checkbox"/> Difficulties regulating their emotions to a greater extent than other children their age <input type="checkbox"/> Intense interests which are unusual in content and/or scope <input type="checkbox"/> Repetitive behaviours (e.g., "stimming") incl. echolalia	

**e) How do these difficulties present at:**Home:School:**f) What has led to the CYP/parent/guardian seeking a referral for ASD diagnostic assessment now?****g) In what way does the CYP/parent/guardian hope to benefit from an assessment for ASD?****6. RISK**

Has the child or young person:	Recent/ongoing (Within past 6 months)	Historic (6+ months ago)	Never
a) Self-harmed to a degree that has required treatment by a healthcare professional (e.g., stitches)?			
b) Self-harmed by head banging, hair pulling, scratching, superficial cutting, or other ways that have not required medical attention?			
c) Made an attempt to end their life?			
d) Expressed thoughts about ending their life or that they would be better off dead?			
e) Engaged in risky behaviour, e.g., use of drink and drugs, theft, or other criminal behaviour?			
f) Harmed another person to the extent that person has required treatment by a healthcare professional?			

Psicon are only commissioned to undertake ASD assessments, and we are not commissioned to provide mental health support. We are therefore unable to accept referrals where a CYP is at risk to themselves, to others or from others.

If you have ticked "Recent/ongoing" for any of the above, we will be unable to accept the referral. Please refer to Hampshire or Isle of Wight CAMHS. Please also refer all CYPs with mental health concerns alongside suspected ASD to Hampshire or Isle of Wight CAMHS.

If in any doubt about mental health presentation or risk, please refer CYP to CAMHS who will consider any co-morbidity.

g) If you selected "Historic" for any of the above, please provide details (including whether support was received at the time or if any services were involved/informed)

## 7. SUPPORTING INFORMATION

Please attach any relevant clinical correspondence and reports – important information includes:

- current/past assessment reports (Neurodevelopmental, OT, SLT, etc.)
- copies of reports from previous involvement with CAMHS
- GP medical summary

### a) Please tick if the CYP has any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> MILD learning disability                  | <input type="checkbox"/> Diagnosed ASD  |
| <input type="checkbox"/> MODERATE-SEVERE learning disability       | <input type="checkbox"/> Diagnosed ADHD |
| <input type="checkbox"/> Suspected UNDIAGNOSED learning disability | <input type="checkbox"/> Dyslexia       |
|  | <input type="checkbox"/> Dyspraxia      |

### b) Please describe any diagnoses and/or current concerns regarding the CYP's mental health:

### c) Please list any diagnoses and/or current concerns regarding the CYP's physical health:

### d) Please list any other medication prescribed for the CYP (medication name and dose):

### e) If applicable, please detail any relevant information not requested above:

**8. ADDITIONAL NEEDS**

	<b>CYP</b>	<b>Parent/Guardian</b>
British sign language interpreter	Yes/No	Yes/No
Step free access/ground floor consulting room	Yes/No	Yes/No
Interpreter required	Yes/No	Yes/No
Hearing impairment	Yes/No	Yes/No
Visual impairment	Yes/No	Yes/No
Further information:		

**9. CONSENT**

a) The CYP/parent/guardian has given consent for the information provided within this referral to be sent to the care provider.	Yes/No
b) The CYP/parent/guardian has provided consent for the care provider to access the summary/full GP record for the duration of the period of care providing there is a legitimate reason to do so.	Yes/No

**10. SIGNATURE**

Referrer Signature:	
Today's Date/Date of Referral:	

Please note that we are unable to backdate referrals. Referrals will be processed by the date this form is received to [kmccg.psicon.childrens@nhs.net](mailto:kmccg.psicon.childrens@nhs.net)

Psicon handle your personal information in accordance with the Data Protection Act 2018 and the General Data Protection Regulations 2018. We will process personal information in ways that respect your individual rights and in line with our company values, exercising the highest standards of confidentiality, integrity, and trust. For more information, please see the Privacy Notice on our website (bottom left on our home page). You can also request a copy from one of our reception areas or by emailing [enquiries@psicon.co.uk](mailto:enquiries@psicon.co.uk)