

**Referral for Assessment for Adult Autism Spectrum Disorder**

***Please note that we cannot assess people who have learning disabilities.***

***Please ensure that this referral form is completed in full and both parts need to be returned together. Incomplete forms will cause delays.***

**Please note:**

*The service cannot assume responsibility for risk management and currently* **cannot** *provide:*

* Case Management
* Emergency appointments
* Ongoing care coordination
* Crisis management
* Specialist interventions

*Should the patient feel in crisis, we would recommend the following:*

* Attending their GP practice. The GP may consider referral to secondary mental health services
* SABP Crisis Line 0800 915 4644 or SMS 07717 989 024
* Local Safe Havens (<https://www.sabp.nhs.uk/our-services/mental-health/safe-havens>)
* Contacting The Samaritans (Tel: 116 123)
* Contacting NHS Choices ([www.nhs.uk](http://www.nhs.uk)) or NHS 111 (Tel: 111) who will have up to date information about resources in the local area.
* Attending their local A&E department where there is access to a mental health specialist

**Please send the completed referral (Parts 1 and 2) to:**

|  |  |  |
| --- | --- | --- |
| **Surrey and North East Hampshire Neurodevelopmental Service** Horizon House, 28 Upper High Street,Epsom, Surrey KT17 4QJTel: 01372 216490Email: rxx.ASDSurrey@nhs.net  | **Hampshire Neurodevelopmental Service**1st Floor, 2 Dickson House,Alencon Link, Basingstoke, Hampshire,RG21 7ANTel: 01256 361180Email: rxx.hampshireautismsabp@nhs.net | **Portsmouth Neurodevelopmental Service** Horizon House, 28 Upper High StreetEpsom, Surrey KT17 4QJT: 01372 216490rxx.Portsmouth-ASD-Diagnostic-Service-SABP@nhs.net |

**PART 1: for the GP/ Referrer to complete**

Date of referral:

**Referrer details**

Name:

Address:

Tadley Medical Partnership,

Franklin Ave, Tadley RG26 4ER

0118 981 4166

Telephone No:

Profession:

GP

**Details of person referred**

Name:

NHS No:

Gender:

D.o.B:

Current address:

Telephone: Home Mobile

Email:

**Preferred method of contact**

⬜ Telephone ⬜Email ⬜ Letter ⬜ SMS

**Virtual appointments**

⬜ Prefer a virtual appointment

⬜ No preference

⬜ Prefer not to have a virtual appointment (state reason(s):

Has the person consented to this referral? Yes⬜ No ⬜

Does the person have a diagnosed learning disability? Yes ⬜ No ⬜

If YES, we will be unable to accept your referral. Please contact or refer to the local Community Learning Disability Services.

**GP details**

Name:

Tadley Medical Partnership,

Franklin Ave, Tadley RG26 4ER

Surgery address:

Telephone number: Email address:

0118 981 4166

**As recommended in the NICE ASD Guideline**, please also return a completed copy of the AQ10 that has been sent with this referral.

**Risk Information** *Due to the high demand for this service, there can be a delay of up to three years between referral and assessment. It is recommended that patients contact their referrer should they require support or advice during this time. The referrer should consider this delay when planning care and support during this period.*

Are there any risks associated with this referral e.g., risk of harm to self or others?

Please give details:

Are there any safeguarding concerns for the individual or members of their family?

Please give details:

**PART 2: for the person to be referred to complete**

**Please provide examples of the current AND historical difficulties you have in the following areas:**

**Social Interaction**

**Consider:**

* Are you able to have a two-way conversation which is easy and natural to you? What about when you were a child?
* Can you initiate and respond to interactions with family, friends, work colleagues? What about when you were a child?
* Do you have to think through social interactions and is this tiring? What about when you were a child?

**Social Communication**

**Consider:**

* Do you use non-verbal communication (gestures, eye-contact, facial expressions, tone of voice) in a way that feels comfortable? What about when you were a child?
* Do you have difficulties with making and maintaining friendships (or relationships)? What about when you were a child?

**Stereotypic, rigid, or repetitive behaviours; resistance to change and restricted range of interests**

**Consider:**

* Do you have certain routines and rituals that must be completed? What about when you were a child?
* Do you have any unusual repetitive movements (i.e., hand flapping, rocking, spinning)? What about when you were a child?
* Do you have any interests that are unusual in strength or content (please describe)? What about when you were a child?
* Do you have any unusual responses to sensory inputs (i.e., noise, lights, texture etc.)? What about when you were a child?

**Please use the space below to add any other information you think would be relevant to your referral:**

