**Autism Spectrum Condition Service**

**Practitioner Referral Form**

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| Patient Name: |  | Date of Birth: |
| Date of Referral: | GP Surgery: | Name of Referring Practitioner:Profession: |
| Patient Address: |  |
| Patient Telephone Number: |  | Can message be left?**Yes / No** | Preferred number/**Do not** contact at this number |
| Does the patient consent to a message being left with a family member? | **Yes / No**Their name:Their relationship to patient (e.g. parent/spouse/partner) |
| Patient MobileNumber: |  | Can voice/text message be left:**Yes / No** | Preferred number/**Do not**contact at this number |
| Patient Email address: |  |
| Does patient have any hearing/language/sensory/mobility difficulties? | **Yes / No** |

The Assessor may request access to patient’s medical notes from the patient’s GP as part of their assessment. All patient information will remain confidential and will only be used to inform this assessment.

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| Does the patient consent to this access to the medical notes? **Yes / No** |

**RATIONALE FOR REFERRAL: please outline reasons for referral at this time and attach relevant information, especially from early developmental history and co-morbid diagnoses**

**N.B. Referral will NOT be accepted if insufficient information provided here**

**Using the subheadings below, please provide a description of the specific difficulties that the patient is experiencing:-**

Social and Communication Difficulties:

Difficulties with Rigid/Repetitive Behaviours, Restricted Interests or Routines:

Impact of above difficulties on general functioning and wellbeing:

Please also add summary of the patient’s view of their presenting problem(s) if different to the above:

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| Is the patient currently receiving any support from mental health services?Has the patient had any prior involvement with mental health services?Has the patient ever had a prior assessment for autism or Asperger Syndrome before? | **Yes / No (**if **yes** please give details)**Yes / No** (if **yes** please give details)**Yes / No** (if **yes** please give details) |
| Risk Information | Please provide details. N.B. referral will not be accepted if not completed: |
| Any known risk to client, clinicians or others |  |
| Any known forensic history or threatening behaviour? |  |
| Any substance misuse issues? |  |