

**YOUNG PEOPLE AND FAMILIES MENTAL HEALTH SERVICE**

**REFERRAL CRITERIA FOR AUTISTIC SPECTRUM DISORDER (ASD) ASSESSMENT**

**The referrer must specify that they are requesting an ASD assessment and consent from parents (and the child if age 14 years and over and has capacity to consent) for this assessment must have been obtained.**

If a referrer would like to discuss a child before making a referral, a telephone consultation with a member of the ASD Team can be arranged by phoning 0300 124 0093 (option 3).

**There must be evidence of deficits in:**

1. **Social communication and interaction, and;**
2. **Restricted/repetitive patterns of behaviour or interests.**

These are the core impairments that are seen in children with ASD. Examples of these deficits can be found on the next two pages, along with space for referrers to record their observations and concerns. This form can be used instead of or alongside the generic referral form for the Young People and Families Mental Health Service. You would use both if, for example, you are requesting an ASD assessment and CBT for anxiety.

We do not accept referrals where the concern is difficult or challenging behaviour only.

If reports from other agencies, such as the Educational Psychology Service, Spectra, Woodlands, the Child Development Centre and Speech & Language Therapy are available, these should be attached to the referral. Please note that if written information does not support the referrer’s concerns in the above areas, the referral will not be accepted.

**The child’s difficulties cannot be explained by developmental delay or learning difficulties, safeguarding issues or attachment problems, or mental health.**

**The child is age 5 years and over.**

Referrals for ASD assessment for children under the age of 5 years who are not in full-time education should be made to the Child Development Centre in the first instance. If the child is due to start school shortly, the referral may be passed to our service for review.

**REFERRAL FORM FOR AUTISTIC SPECTRUM DISORDER (ASD) ASSESSMENT**

|  |  |
| --- | --- |
| **Child/young person details** | |
| Name of child: |  |
| DOB: |  |
| NHS number: |  |
| Address: |  |
| Telephone number: |  |
| Name of parents/carers: |  |
| Name and address of GP: |  |
| Name and address of school: |  |
| Name and address of Social Worker if child is in care: |  |
| **Referrer details** | |
| Name and job title of referrer: |  |
| Address: |  |
| Telephone number: |  |
| Date of referral: |  |
| **Reason for referral** | |
| |  |  | | --- | --- | | Tick this box to confirm you are requesting an ASD assessment | **□** | | Tick this box to confirm you have discussed the referral with an adult who has parental responsibility for the child and they have agreed to you making the referral | **□** | | If the child is age 14 years and over and has capacity to consent, tick this box to confirm you have discussed the referral with the child and they have agreed to you making the referral | **□** | | |
| **Summary of main concerns** | |
| Please insert a summary of your main concerns: | |
| **Social communication and interaction** | |
| Please highlight specific areas of difficulty in relation to:  *Social-emotional reciprocity:* failure to initiate or respond to social interactions (child may avoid, be intense or lack awareness, or follow a learnt ‘script’ during social situations);does not follow conversational rules (e.g. listening, taking turns); reduced sharing of interests or feelings; speaks with an accent or unusual tone or volume  *Non-verbal communication:* failure to use eye contact, body language, gesture and facial expression during social interactions; and difficulty understanding these  *Developing, maintaining and understanding relationships:* lack of interest in peers; absence of friendships and lack of understanding of friendships; difficulty adjusting behaviour to suit various social contexts; poor imaginative play | |
| **Restricted/repetitive patterns of behaviour or interests** | |
| Please highlight specific areas of difficulty in relation to:  *Stereotyped or repetitive motor movements, use of objects or speech:* unusual hand or body movements; lining up toys and flipping objects; repeating the speech of others; distinctive phrase speech  *Insistence on sameness:* adherence to routines (and anxiety if routines are changed); verbal and behavioural rituals (and agitation if prevented from completing particular rituals)  *Restricted and fixated interests:* interests that are unusual in their focus or intensity  *Sensory sensitivity:* sensitivity to light, sound, touch, taste or textures (to the extent that certain environments are avoided); lack of sensitivity to pain and low/high temperatures; interest in sensory features of the environment (e.g. smelling people, visual examination of lights) | |
| **Other relevant information** | |
| Please insert any relevant background information (e.g. past and current diagnoses, family history of ASD or mental health issues, learning ability, safeguarding issues): | |
| **Supporting information** | |
| Tick box if the child is known to any of the following services, and attach a copy of the most recent report to the referral   |  |  | | --- | --- | | Child Development Centre or Community Paediatrics | **□** | | Speech & Language Therapy | **□** | | Educational Psychology Service | **□** | | Spectra | **□** | | Woodlands | **□** | | Other (please specify………………………………………………………………..) | **□** | | |

**Thank you for completing this form. We will be in touch shortly.**

**Completed forms should be emailed to** [**025spa@sssft.nhs.uk**](mailto:025spa@sssft.nhs.uk) **or posted to:**

**Access Team**

**Redwoods Centre**

**Somerby Drive**

**Bicton Heath**

**Shrewsbury**

**SY3 5DS**

We welcome feedback on the referral process. Please send any comments to the above email address or postal address.