## ADULT AUTISM DIAGNOSTIC TEAM

For people 18 years of age and above

## REFERRAL FORM

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| **Name:** | **Date of birth:** |
| **Address:**  **Email:** | **Telephone number(s):**  **NHS Number (if known):** |
| **Ethnic Origin:** |
| **Next of kin:**  Name:  Contact number: | **Dependants:** |
| **Referred by:**  Self □  Other □ If other please state who and your role  Date of referral: | **Referrers address:** (If not self-referral) |
| **GP Address:** | **Is the person being referred in agreement with the referral?**  Yes □  No □ |
| **What is the person’s preferred way to be contacted?**  □ phone  □ text  □ email  □ letter | **Any other services involved** |

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| **What is this referral requesting?**  □Autism Diagnosis (Please fill in section below)  □Other (please state) |

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| **What characteristics suggest the person being referred might be autistic**  **Please give any examples below**  issues in communication  issues with social interaction  need for routines  sensory issues  other relevant information |

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| **Referral Triaged by** | **Triage Date** | **Allocated Team** |
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**Post to: Autism Service, Hollingworth Clinic, Market Street, Hollingworth, Hyde, SK148HR**

**Or email referral to:** [communitycentralbooking@tgh.nhs.uk](mailto:communitycentralbooking@tgh.nhs.uk)