##  ADULT AUTISM ASSESSMENT REFERRAL FORM

**This service is for Autism assessment ONLY. For ADHD or any other neurodevelopmental assessment please contact the relevant teams. The service is for people who are 18 years old and above**

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| **Name:** | **Date of birth:****Age:** |
| **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 roleDate of referral: | **Referrers address and phone number:** (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 characteristics suggest you/ the person being referred might be autistic** **Please give any examples below**Issues in communication (please include examples)Issues with social interaction (please include examples)Need for routines/resistance to change (please include examples)Restricted and/or intense interests (please include examples)Sensory issues (please include examples)Other relevant information  |
| **Information: An autism diagnosis involves 3 separate assessments; An initial screening assessment, a developmental history (to gather information from your childhood) and a formal diagnostic assessment (ADOS).** |

**Post to: Autism Service, Hollingworth Clinic, Market Street, Hollingworth, Hyde, SK148HR**

**Or email referral to:** communitycentralbooking@tgh.nhs.uk