 

**Consultancy Request Form:** Leeds Autism Diagnostic Service

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| **ALL** parts of this **Professional Consultancy** request form should be fully completed. Failure to complete all fields will result in a service decline letter being issued. **For your referral to be accepted for consultancy the service user must: -**

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| **1 –** Be aged 18 or above **2 -** Under LYPFT services for at least 3 months from the point of referral. **3 –** Have a diagnosis of autism **4 -** have complex needs and/or high levels of risk.Please return the completed form to referral.lypft@nhs.net. Please **do not** send the referral form directly to the service or individual team members.  If you are not sure if your service user meets the consultation criteria, please contact us to discuss further on 0113 8550712.

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| **REFERRAL DETAILS** |
| **DATE OF REFERRAL** | Click or tap here to enter text. |
| **REFERRER DETAILS**  | Name Click or tap here to enter text.Profession Click or tap here to enter text.Address Click or tap here to enter text.Contact Number/EmailClick or tap here to enter text. |
| **SURNAME** | Click or tap here to enter text. |
| **FORENAME** | Click or tap here to enter text. |
| **ADDRESS INC TOWN, COUNTY & POSTCODE** | Click or tap here to enter text. |
| **EMAIL ADDRESS** | Click or tap here to enter text. |
| **TELEPHONE NUMBER** | Click or tap here to enter text. |
| **DATE OF BIRTH** | Click or tap here to enter text. |
| **NHS NUMBER** | Click or tap here to enter text. |
| **GENDER** | [ ] Male [ ] Female [ ] Non-binary [ ] Prefer to self-describe Click or tap here to enter text. | Is gender identity the same as assigned gender at birth?[ ] Yes [ ] No [ ] Prefer not to say  |
| **SEXUALITY:** Which of the following best describes the service users sexuality? | [ ]  Heterosexual or straight [ ] Gay or Lesbian[ ]  Bisexual [ ] Not known [ ]  Other sexual orientation not listed[ ]  Does not wish to disclose |
| **ETHNICITY** | Click or tap here to enter text. |
| **EMPLOYMENT STATUS** | Click or tap here to enter text. |
| **VETERAN STATUS** | Tick here if ever served in the UK armed forces: [ ]  |
| **CONSENT** | Does the service user fully consent to the referral?[ ] Yes [ ] No  |
| **CARER DETAILS** |
| **NAME** | Click or tap here to enter text. |
| **ADDRESS INC TOWN, COUNTY & POSTCODE** | Click or tap here to enter text. |
| **TELEPHONE NUMBER** | Click or tap here to enter text. |
| **E-MAIL** | Click or tap here to enter text. |
| **GP DETAILS** |
| **NAME** | Click or tap here to enter text. |
| **ADDRESS INC TOWN, COUNTY & POSTCODE** | Click or tap here to enter text. |
| **TELEPHONE NUMBER** | Click or tap here to enter text. |
| **E-MAIL** | Click or tap here to enter text. |

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| **CONSULTANCY REQUEST DETAILS:** all information listed below is required for the service to assess the appropriateness of your referral.  |
| a) Please outline the **reasons** you are submitting a consultancy request for the service user. What outcome are you hoping for in meeting with the Leeds Autism Diagnostic Service team?  |
| Click or tap here to enter text. |
| b) Please describe the service users’ **current difficulties** (e.g., social circumstances, physical health, mental health, medication if known). What have you already offered to support them, including autism-related reasonable adjustments? |
| Click or tap here to enter text. |
| c) Please briefly describe any relevant **risk** information |
| Click or tap here to enter text. |
| d) Does the service user have a copy of previous diagnosis reports or previous assessments? |
| [ ]  Yes [ ]  No**If yes, please attach with the referral form.**Were they diagnosed with autism by the Leeds autism diagnostic service? [ ]  Yes [ ]  NoIf yes, we will have it on record.If not diagnosed by our service, and no report is available, please contact GP or family to obtain the report prior to submission of referral form.If a diagnostic report is not available, please contact our service to discuss alternative information sources but be aware we may not accept the referral. |
| e) Who should be involved in the consultation process  |
| Professional(s) (please state name and profession) Click or tap here to enter text.Carer: Click or tap here to enter text.Relative: Click or tap here to enter text.Please note, normally we would expect the professional present in the consultation to be involved for at least 3 months after the consultation process, in order to help implement any actions/recommendations.  |
| f) Recent risk assessment, care plan, and safety plan visible? |
| Has the risk assessment been completed in the last 2 months?[ ]  Yes [ ]  NoHas a safety plan been developed with the service user and visible on clinical record?[ ]  Yes [ ]  NoHas a care plan been developed with the service user and visible on the clinical record?[ ]  Yes [ ]  No |

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| **SERVICE USER REQUIREMENTS** |
| f) Do they have any other diagnosed conditions: |
| [ ]  ADHD[ ]  Learning Disability[ ]  Dyslexia[ ]  Dyspraxia | [ ]  Hearing Impairment / Deafness[ ]  Visual Impairment / Blindness[ ]  Other, please specify: Click or tap here to enter text. |
| g) Do you have any additional needs or require any reasonable adjustments in these areas (please describe): |
| [ ]  Mobility, e.g., do you use a wheelchair Click or tap here to enter text.[ ]  Sensory, e.g., do you need a quiet waiting area Click or tap here to enter text.[ ]  Communication, e.g., do you need information in Easy Read, British Sign Language, Braille Click or tap here to enter text.[ ]  Interpreter: If yes, which language? Click or tap here to enter text.[ ]  Other, e.g., support from carer Click or tap here to enter text. |

Last updated: 23/02/22

**ALL** parts of this form should be fully completed to be considered by the service for a consultancy appointment. Failure to complete all fields will result in a service decline letter being issued.

Please return the form to referral.lypft@nhs.net

**Equality and Inclusion information**

We would be grateful if you could please provide us with the following information. By doing this you are helping us to monitor the uptake of or services and aid the planning process to ensure that a culturally competent service is provided to our patients. Personal data about you is not shared with anybody not directly involved in your care.

**ETHNICITY:**

|  |  |  |
| --- | --- | --- |
| Asian – Pakistani |[ ]  Black – African |[ ]  White – British |[ ]
| Asian – Indian |[ ]  Black – African |[ ]  White – Irish |[ ]
| Asian – Bangladeshi |[ ]  Black – Other |[ ]  White - other |[ ]
| Asian – Other |[ ]  Chinese |[ ]   |  |
| Mixed (please specify): Click or tap here to enter text. | Other ethnic group (please specify)Click or tap here to enter text. |

**RELIGION:**

|  |  |  |
| --- | --- | --- |
| Baha’I |[ ]  Jain |[ ]  Pagan |[ ]
| Buddhist |[ ]  Jewish |[ ]  Sikh |[ ]
| Christian |[ ]  Muslim |[ ]  Zoroastrian |[ ]
| Hindu |[ ]  None |[ ]  Other |[ ]

**MARITAL STATUS:**

|  |  |  |
| --- | --- | --- |
| Divorced  |[ ]  Surviving partner / widowed |[ ]  Separated |[ ]
| Married/ civil partner |[ ]  Single |[ ]   |  |

**LIVING STATUS:**

|  |  |  |
| --- | --- | --- |
| Lives alone |[ ]  Lives with parent/ guardian |[ ]  Residential care |[ ]
| Lives with family |[ ]  Lives with partner/ spouse |[ ]  Supported living |[ ]
| Lives with other |[ ]  No fixed abode |[ ]   |  |

**EMPLOYMENT STATUS:**

|  |  |  |
| --- | --- | --- |
| Employed |[ ]  Unemployed – Seeking work |[ ]  Student |[ ]
| Looking after Family/ Home |[ ]  Unemployed – Not seeking work |[ ]  Other |[ ]
| Retired  |[ ]  Unemployed – Sick/ Disabled |[ ]  Unpaid/Voluntary |[ ]

 **NEXT-OF-KIN INFORMATION:**

|  |  |
| --- | --- |
| **NAME:** Click or tap here to enter text. | **ADDRESS:** Click or tap here to enter text. |
| **CONTACT INFORMATION:** | **Landline:** Click or tap here to enter text. | **Mobile:** Click or tap here to enter text. |
| **NEXT-OF-KIN RELATIONSHIP TYPE** | Husband/Wife |[ ]  Son/Daughter |[ ]  Father/ Mother |[ ]  Brother/ Sister |[ ]
|  | Grandparents |[ ]  Grandchild |[ ]  Uncle/Aunt |[ ]  Nephew/Niece |[ ]
|  | Common-Law spouse |[ ]  Civil partnership |[ ]  Other Click or tap here to enter text. |

**CARER INFORMATION:**

|  |  |  |
| --- | --- | --- |
| **Do you have a Carer?** | **YES** [ ]  | **NO** [ ]  |
| **Name of Carer:** Click or tap here to enter text. | **Address of Carer:** Click or tap here to enter text. |
| **Contact number of carer:** Click or tap here to enter text. | **Relationship to service user:** Click or tap here to enter text. |

**SEXUALITY:**

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| --- |
| **Which of the following best describes how you think of yourself? *(please tick)*** |
| Heterosexual or Straight | [ ]  | Gay or Lesbian | [ ]  | Bisexual | [ ]  |
| Rather not say | [ ]  | Not sure | [ ]  | Other Sexual Orientation not listed (please state)Click or tap here to enter text. |

**RESEARCH:**

|  |
| --- |
| We sometimes invite service users to take part in research. Please tick here if you would like to hear about research opportunities after you are discharged from the service.[ ]  Yes, I would be happy to be contacted about research[ ]  No, I would rather not be contacted about research |
|  |