A close-up of a logo

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**Leeds Autism Diagnostic Service referral form**

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| --- | --- | --- | --- | --- | --- |
| **ALL** parts of this referralform should be fully completed to be considered by the service for an initial assessment. Please answer all questions or your referral may be declined. If a question does not apply to you, please put ‘N/A’. **Please return the completed form to** [referral.lypft@nhs.net](mailto:referral.lypft@nhs.net)  **For the service to accept a referral the following criteria must be met: -**   |  | | --- | | **1 –** Be aged 18 or above **3 –** Have not received a previous diagnosis of autism  **2 –** Fully consent to the referral **4 –** Be registered with a Leeds GP  **PLEASE NOTE:** If there is a mental health or substance misuse problem which is currently so unstable it may affect the autism assessment, please contact us to discuss before sending the referral, on **0113 855 0712**. | |  | | | | |
|  | | | |
| **SERVICE USER DETAILS** | | |
| **TYPE OF REFERRAL** | Professional referral Self-referralFamily/carer | |
| **DATE OF REFERRAL** | Click or tap here to enter text. | |
| **SURNAME** | Click or tap here to enter text. | |
| **FORENAME** | Click or tap here to enter text. | |
| **GENDER** | Male  Female  Non-binary  Prefer to self-describe  Click or tap here to enter text. | Is your gender identity the same as your assigned gender at birth?  Yes  No  Prefer not to say |
| **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. | |
| **GP SURGERY** | Click or tap here to enter text. | |
| **VETERAN STATUS** | Tick here if you have ever served in the UK armed forces: | |
| **REFERRER DETAILS (If not self-referral)** | | |
| **NAME** | Click or tap here to enter text. | |
| **PROFESSION** | Click or tap here to enter text. | |
| **ADDRESS** | Click or tap here to enter text. | |
| **EMAIL** | Click or tap here to enter text. | |
| **CONSENT** | Does the service user fully consent to the referral? Yes No *(Please obtain consent - referrals are not accepted into the service if full consent is not given)*  Service user lacks capacity to consent to autism assessment *(Please explain in referral reason why autism assessment is in the patient’s best interests)* | |

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| **REFERRAL DETAILS:** all information listed below is required for the service to assess the appropriateness of the referral. |
| a) **Please outline the reason for the referral and level of need**. Why do you need an autism assessment at this time? If you have had a referral to us declined in the past, what has changed since? |
| Click or tap here to enter text. |
| b) **Social Interaction:** Please provide examples of **current** and **childhood difficulties** and how these cause(d) problems in day-to-day life: e.g. difficulty making and maintaining friends, difficulty understanding social situations, inappropriate social behaviour such as ‘saying the wrong thing’ |
| **Childhood:**  Click or tap here to enter text.  **Current:**  Click or tap here to enter text. |
| c) **Social Communication:** Please provide examples of **current** and **childhood difficulties** and how these cause(d) problems in day-to-day life:e.g. eye contact, use of gestures, unusual speech (such as monotone voice) |
| **Childhood:**  Click or tap here to enter text.  **Current:**  Click or tap here to enter text. |
| d) **Restricted and Repetitive behaviours:** Please provide examples of **current** and **childhood difficulties** and how these cause(d) problems in day-to-day life:e.g. rigid routines, resistant to change, intense interests, literal thinking |
| **Childhood:**  Click or tap here to enter text.  **Current:**  Click or tap here to enter text. |
| e) **Sensory Issues:** Please provide examples of **current** and **childhood difficulties** and how these cause(d) problems in day-to-day life:e.g. over or under sensitivity to touch, light, smell, taste, noise or pain. |
| **Childhood:**  Click or tap here to enter text.  **Current:**  Click or tap here to enter text. |
| f) Can you explain how any of the possible autistic features you have identified above may impact on areas of your life (for example, home life, relationships, work, education, health)? |
| Click or tap here to enter text. |
| g) Can written information be provided from childhood to help support the assessment process, e.g. school reports, mental health service reports etc. |
| Yes (please specify) Click or tap here to enter text.  No |
| h) Please provide information about any current or previous physical and mental health diagnosis and details of current medication **(or attach GP summary care record.)** |
| Click or tap here to enter text. |
| i) Have you had an autism assessment previously? If so, what was the outcome of this assessment? |
| Yes   No  Outcome: Click or tap here to enter text. |
| j) Are you at risk of self-harm or harming others? |
| Yes – please give details Click or tap here to enter text.  No |

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| **DEVELOPMENTAL HISTORY** |
| Autism is very challenging to diagnose without developmental history. As part of our diagnostic process, we normally invite a relative or friend to provide additional information. This may be in the form of a questionnaire, or an interview completed with a clinician.  If your referral is accepted the first stage of the pathway is gathering the developmental history. Therefore, we require the developmental history questionnaire to be returned to the service before you can be offered a first appointment. The developmental history questionnaire can be found on our website.  **Please be aware that without a developmental history, we are sometimes unable to make a confirmed diagnosis of autism.** |
| k) Is there a family member (usually a parent) that knew you well during childhood who would be willing to take part in the diagnostic process? |
| Yes, I have someone in mind and would be comfortable for you to contact them.  No, I do not have anyone in mind to take part in the diagnostic process.  If |

|  |  |
| --- | --- |
| **SERVICE USER REQUIREMENTS** | |
| l) Do you have any other diagnosed neurodevelopmental conditions: | |
| ADHD  Learning Disability  Dyslexia  Dyspraxia | Hearing Impaired / Deaf  Visual Impaired / Blind  Other, please specify Click or tap here to enter text. |
| m) 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., do you need someone to come to appointments with you Click or tap here to enter text. | |
| n) **Appointment Type:** Which type of appointment would you prefer? (The service will consider your preference, however some appointments on the pathway require a face-to-face appointment) | |
| Face-to-face  Videocall (if this is the preferred option you need to have access to a laptop or tablet and a good internet connection) | |
| o) **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 | |
| p) **Communications consent: How would you like us to contact you**? | |
| |  |  |  | | --- | --- | --- | |  | Yes | No | | Phone |  |  | | Letter |  |  | | Text Message |  |  | | Voicemail message |  |  | | Email |  |  | | |

Last updated: 03/11/2023

**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 (please state)  Click or tap here to enter text. | | | | |

**CARER INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have a Carer?** | **YES** | | **NO** |
| **Name of Carer:** | | **Address of Carer:** | |
| **Contact number of carer:** | | **Relationship to service user:** | |

**SEXUALITY:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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. | |