Date Received: _____ System Logged: _____ V2.1

Adult Spectrum Disorder Service - Referral Form

This referral is requesting Diagnostic Assessment ☐ **Post Diagnostic Support** ☐

- The Adult Autism Spectrum Disorder Service accepts referrals for individuals aged 18+ who present with signs which suggest a possible Autism Spectrum Disorder (ASD).
- If this referral is for a service other than diagnostic assessment please attach relevant diagnostic report/s confirming an ASD diagnosis.
- Please note that referrals can be accepted *only* where the purpose of the referral has been fully discussed with the client or named carer and consent has been agreed.
- Referrals which fail to meet the specified criteria will be returned to the referring agent.

Has this referral been discussed with the client? **Yes** ☐ **No** ☐

Does the client have capacity to consent to this referral? **Yes** ☐ **No** ☐

Has consent to this referral been given by the client? **Yes** ☐ **No** ☐

If you have entered *no* to any of the above questions; please explain: _____

_____

Intellectual Disability

Does the client have an Intellectual Disability Diagnosis? **Yes** ☐ **No** ☐

(If you have answered no please continue on to personal information section.

If answered yes please attach relevant diagnostic report).

Please tick the box that best describes the client's attendance at Learning Disability Services:

No Involvement ☐ Currently involved ☐ Previously Involved ☐

Personal Information

Name: **D.O.B:** **Age:** **H & C Number:** **Gender:** **Language(s) spoken at home:**	
Full Address: **Postcode:**	**Telephone Number:** **Mobile Number:**
General Practitioner: **Surgery Address:** **Postcode:**	**Telephone Number:**
Family Structure/Genogram: **Number of residents in household:**	

Information to aid access to the service	
Does the client require another person to assist them in organising and attending appointments? Yes ☐ No ☐ If yes please provide details below:	
Contact Name:	**Address (If different to client):**
Contact Number:	
Relationship to client:	

Risk						
	Past	**Current**		**Past**	**Current**	**Additional comments**
Self-Harm	☐	☐	**Alcohol Abuse**	☐	☐	
Suicidal Ideation	☐	☐	**Forensic**	☐	☐	
Neglect	☐	☐	**Aggression**	☐	☐	
Drug Abuse	☐	☐	**Violence**	☐	☐	

Professionals / Agencies Involved	
Professionals/Agencies CURRENTLY Involved	**Professionals/Agencies PREVIOUSLY Involved**
Daycare/School/Education/Work/Training CURRENTLY Involved.	**Previous School/ Educational Attainments**

Reason for referral: Briefly outline the reasons for referral to the ASD service. (Specific concerns to be provided further in the form).
History/Development: Please state specific concerns/possible indications of ASD
Please state evidence of developmental delays other than that associated with intellectual disability?

Current Presentation: Please state specific concerns/possible indications of ASD
Communication ability: e.g. Level of understanding/expressive language. Unusual characteristics of communication (i.e. accent, intonation, vocabulary). Unusual characteristics of non-verbal communication (i.e. difficulties with eye contact);
Quality of social functioning / social interaction with family / peers / strangers (please provide examples):
Concerns re: restricted interests/leisure or repetitive patterns of behaviour/sensory issues (please provide examples):
Behavioural concerns: (e.g. poor sleep; dietary concerns; aggression/self harm; obsessive behaviours; coping with change, please provide examples):
Psychological / Medical / additional needs: (to include co-morbid diagnoses, medication, hearing visual or mobility difficulties).

Referred by:	**Profession:**	**Date:**
Referrer Signature:	**Telephone Number:**	

Please return completed form to:

Adult ASD Services, Oldbridge House, Glendermott Road, L'derry BT47 6AU

Alternatively

Please contact us on 028 71320167 if you wish to this discuss referral.