TAAS Team

John Parks Unit

Torbay Hospital Annexe

187 Newton Road

Torquay

TQ2 7BA

Hospital Tel No: 01803 614567

# DIRECT DIAL FOR DEPT: 01803 655827

**Torbay Autism Assessment Service**

**REFERRAL FORM**

**This form is to be used for children aged 5-18 years who are registered with a GP in the Torbay area.**

Dear Referrer,

Given the complex nature of the assessment of children and young people with a suspected Autism Spectrum Disorder, it is necessary to obtain as much background information as possible in the first instance. Hence, please fill in the form, giving as many details as possible.

**Patient Name:**

**Date of Birth:**

**Hospital Number:**

**NHS number:**

**Address:**

**Patient Contact number(s):**

**GP details:**

**Name of Referrer:**

**Professional Status:**

**Clinic/Address:**

**Telephone:**

**Email:**

**Date of referral:**

1. Has the child/young person and/or family agreed to the referral? Yes No
2. Reasons for referral:

(Please continue on a separate sheet if necessary and enclose

any relevant previous reports)

1. Is the child in school or nursery? Yes No

Name and address of school or Nursery:

1. Does the child have special educational needs? Yes No
2. Does the child have an Education, Health and Care Plan?

Yes No

1. Local specialist responsible for the child’s ongoing care:
2. Known generalised developmental delay? Yes No
3. Has the child seen an educational psychologist Yes No

and/or clinical psychologist?

If yes, please state when, by whom and the outcome:

1. Any known generalised Learning difficulties? Yes No

9a. Any known specific Learning difficulties?

Yes No

1. Has the child seen a speech and language therapist? Yes No

If yes, please state when, by whom and the outcome:

1. Has the child’s hearing been assessed? Yes No

If yes, please state when, by whom and the outcome:

1. Has the child’s vision been assessed? Yes No

If yes, please state when, by whom and the outcome:

1. Has the child had a full physical and neurological examination? Yes No

If yes, please state when, by whom and the outcome:

1. Has the child been tested for Fragile X Syndrome? Yes No

If yes, please state when, by whom and the outcome:

1. Have they had a high resolution karyotype? Yes No

If yes, please state when, by whom and the outcome:

1. Any established Medical or Psychiatric diagnosis: Yes No

If yes, when was the diagnosis made and by whom:

1. Previous specialist assessments/agencies (e.g. Occupational Therapy, Physiotherapy, Children’s Services) involved in child’s care, if any:
2. Professional agencies the child is currently known to:
3. Is the child currently on medication? Yes No

If yes, please list:

1. Other interventions/therapies the child is currently on, if any:
2. Are court proceedings underway for this child/young person? Yes No

If yes, please provide additional information:

1. Additional information or relevant family history of Autism Spectrum Disorder, ADHD, tic disorder or language disorder if any:
2. Has a general developmental assessment been completed? Yes No

If so, by whom and outcome:

**Please attach the following:**

1. Pupil with possible social and communication difficulties-questionnaire from school
2. Childhood Asperger Syndrome Test Questionnaire (CAST) for children aged 5-11 years. Social Communication (Lifetime) questionnaire (SCQ) for children over 11.

**Please attach copies of all relevant reports from other professionals.**

**NAME:** (PRINTED) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:**

**Many thanks for completing this form. If the referral is accepted, then you will receive a letter from the team in acknowledgement and the child will go on our waiting list. We will write to the family with an appointment as soon as possible. In the meanwhile, please feel free to contact us if you have any queries.**

Referrals Coordinators

Direct Line: 01803 655827

Email: tsdft.taas@nhs.net