|  |  |
| --- | --- |
|  |  |
|  |

|  |
| --- |
| **Professionals Referral form (for professionals use in partnership with parent & CYP)** **ELHT Autism Pathway - Children and Young People**  |
| **This referral is for assessment of possible** **Autism Spectrum Disorder (ASD) only.*** **This form is for use by Health and Education Professionals working alongside ELHT in Blackburn with Darwen and East Lancashire.**
* **Please complete this form electronically and return to** **ELHTCYPAutismreferrals@elht.nhs.uk**
* ***Please complete all sections - Incomplete referral forms will be returned to the referrer.***
* **It is advised that the referrer should have an established relationship with the child or young person, and able to offer a professional opinion based on 1 or more assessments with the child or young person. If this is not the case, it is recommended that the form be directed to the child/ young person’s school to complete. School referrals will very likely provide high quality referral information and prevent avoidable delays in the triage process.**
* **Please note that there is an ASD assessment service for over 16s, this is provided by Clinical Partners and referral information is accessible here** [**https://www.lancashire.gov.uk/children-education-families/special-educational-needs-and-disabilities/health-and-wellbeing/learning-disabilities-and-autism/lancashire-and-cumbria-autism-support-hub/**](https://www.lancashire.gov.uk/children-education-families/special-educational-needs-and-disabilities/health-and-wellbeing/learning-disabilities-and-autism/lancashire-and-cumbria-autism-support-hub/)
 |
| **SECTION 1 – CHILD/ YOUNG PERSON DETAILS** |
|

|  |  |  |
| --- | --- | --- |
| NHS No: | Date of Birth:  | Gender: M / F / Other Ethnicity:  |
| Name: |  | Surname:  | Language spoken:Interpreter Required:  ☐ Yes ☐ No |
| Address and Postcode: |
| School/Nursery Name, Address and Postcode. Please indicate if home schooled.  |

 |
| **SECTION 2 – REFERRER DETAILS** |
| Name of referrer (print): |
| Designation of referrer (print): |
| Address of referrer: |
| **Referrer Email:** |
| **Date of referral:** |
| **SECTION 3 – FIRST STEPS PRIOR TO REFERRAL**  **– SENCOs should ALWAYS complete this section**  |
| **SUMMARY OF ACTIONS:**

|  |  |
| --- | --- |
| **Please indicate if the following apply** | **Yes/ No** |
| **Child or YP on SEN register** |  |
| **Support in place e.g., IEP, My plan, Pupil support plan**  |  |
| **Additional support measures e.g., nurture provision, family support worker, targeted support offered within school** |  |

If yes to any of above, please provide details and/or any relevant reports e.g., SEND information / Education Psychology report etc. |
| **SECTION 4 – PARENT/CARER/NEXT OF KIN/SIGNIFICANT OTHER DETAILS** |
| Name (s):  Phone number:**Parent Email Address:** |
| Parental responsibility for this child ☐ Yes ☐ No – please state name, address and contact number of the person who has parental responsibility (e.g., local authority, foster carer, social worker etc.): |
| **SECTION 5 - SAFEGUARDING**  |
| Please indicate any known safeguarding concerns (CAF/ CIN? Relevant history)Child protection plan ☐ Yes ☐ No Care order in place ☐ Yes ☐ No |
| **SECTION 6 - CONSENT FOR MULTIDSICIPLINARY ASSESSMENT** |

|  |
| --- |
| **It is essential that consent for multi-disciplinary assessment, as detailed below, be discussed with parent/ carer if the child/ young person is under 16 years of age.** **This can be done verbally by telephone or in person.** |
| 1. I confirm I have discussed as below with parent / carer for the child, and they have confirmed their consent for a referral to be made to the Neurodevelopmental Assessment Pathway

Relevant information about the above-named child or young person to be requested by and shared with relevant organisations and professionals supporting the delivery of the neurodevelopmental pathway.Professionals and assessments required for the social communication assessment are individually considered at triage but may include any of the following services or professionals: Neurodevelopmental Practitioners, Speech and Language therapy, Clinical Psychology, Child and Adolescent Psychiatry, Paediatrician, ADOS Assessment, Child Development Centre Assessment.Information may also be requested from Nursery or School or other agencies or health service, for example General Practitioner, Audiology, Ophthalmology, Specialist Paediatric Services, Children’s Social Care.Sharing of Family history - Parental health issues, Extended family history ASD / ADHD**Name of professional discussing consent:** **Name of parent/guardian giving consent:** **Has this been discussed with child / YP?****Do they also agree to referral?** |

|  |
| --- |
| **SECTION 7: REASON FOR REFERRAL**  |
| **Profile of Child/ Young person****Please indicate concerns raised from observations in the school setting:****If ‘yes’, please provide information below or include further supporting documentation****School/ Nursery Year:**

|  |  |
| --- | --- |
|  | **Are concerns noted in school? Yes/ No** |
| **Attention and listening** |  |
| **Level of activity** |  |
| **Language** |  |
| **Learning** |  |
| **Social skills impacting friendships** |  |
| **Social skills – conversation or general interactions with adults/ peers, eye contact, behaviour with new vs familiar people** |  |
| **Restrictive or Repetitive behaviours – inflexibility, obsessions, fixed thinking** |  |
| **Sensory difficulties**Please give details |  |
| **Are there any other co-existing issues e.g., Dyslexia, DCD (Dyspraxia)**Please give details |  |
| **Any other observations or concerns?**Please give details e.g., anxiety, low mood, school refusal, behavioural issues, school exclusions, school absence concerns, triggers for behavioural difficulties |  |
| **Any other concerns – including additional parental concerns**Please attach parent 1 page profile |  |

 |

|  |
| --- |
| **SECTION 8: SPECIAL/ RED FLAG CONCERNS** |
| **Speech and Language**Are there concerns re: speech sounds, speech disorder, language delay? Are there any issues relating to hearing or speech? Have NHS or school SLT had any involvement previously or currently?**Learning**Is learning expected for age? If delays kindly indicate degree of delay(s)**Wellbeing**Are there any specific life events, or family circumstances which have or may be impacting upon this child’s or young person’s behaviour? E.g., bereavement, family upheaval, traumatic experiences, significant health, or behaviour issues in any family member. Have they ever been in foster care or lived away from the family?Are Child/ Adolescent mental health services involved or any family support mechanisms in place? Do other family members have a diagnosis of ASD or ADHD?**END OF REFERRAL FORM** |

 |

**FOR ELHT ASD PATHWAY INTERNAL USE ONLY**

|  |  |  |
| --- | --- | --- |
| **TRIAGE DATE** |  |  |
| **Person triaging** |  |
| **AREA****(Delete as apt)** | **BwD** | **HRVR** | **BP** | **Out of area** |  |
| **OUTCOME****(delete as appropriate)** | 1. **ACCEPT ASD Pathway**
2. **DECLINE ASD Pathway**

**Reason for decline****A– insufficient information LETTER A** **B – redirect to alternate service LETTER B** **3. CNP appointment – LETTER C**  |
| **IF ACCEPTED****Assessments required:****Tick as apt** | **Pen portrait**  | **SLT** | **ASRS** | **Psychology** | **Other** |
|  |  |  |  |  |
| **ASD Pathway ADMIN actions** | **Add to ASD pathway spreadsheet DATE:****Enter on to PAS****Referral documents to be forwarded to locality team****Send ASD pathway acceptance letter DATE:**  |

|  |  |
| --- | --- |
| **IF DECLINED****Admin actions** | **Decline letter (from template above) DATE:** |

|  |  |
| --- | --- |
| **CNP APPOINTMENT****ASD Pathway ADMIN actions** | **3. CNP only Appointment**Pass to CNP booking office for Paediatrician triage **DATE:** |