**Adult Autism Service**

# PATIENT DETAILS

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **NHS Number:** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Full Address:** |  |
| **Telephone Number:** |  |
| **Mobile Number:** |  |
| **Contact Email:** |  |

1. **REFERRER DETAILS** *(if referrer is GP, please complete section below)*

|  |  |
| --- | --- |
| **Name:** |  |
| **Referral Source:** |  |
| **Address:** |  |
| **Telephone Number:** |  |
| **Contact Email:** |  |

# GP DETAILS

|  |  |
| --- | --- |
| **GP Name:** |  |
| **GMC Number:** |  |
| **GP Surgery Name:** |  |
| **GP Surgery Address:** |  |
| **Telephone Number:** |  |
| **Contact Email:** |  |

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| --- | --- | --- | --- |
| **Referral Pathway** | **Autism Spectrum Disorder Pathway** |  |  |
| **Problems caused by symptoms/behaviours****e.g. anxiety, problems in relationships** |  |  |  |
| **Presentation e.g.****symptoms/behaviours** |  |  |  |

1. **SUPPORTING INFORMATION**

**Please attach relevant clinical correspondence and reports – important information includes:**

* + **current/past CMHT reports**
	+ **previous ASD and or ADHD Assessment letters**
	+ **copies of previous involvement with the Child & Adolescent Service**
	+ **GP Encounter Report**

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| --- |
| **a) Does the patient have a previous diagnosis of ADHD and/or ASD? (Please attach original diagnostic letter as appropriate)** |
|  |
| **b) Does the patient have any psychiatric history? (Please include any details of interaction with Mental Health Teams or hospital admissions)?** |
|  |
| **c) Does this patient have a learning difficulty/disability?** |
|  |
| **d) Does this patient have any diagnosed medical conditions? (If yes, please provide a brief summary)** |
|  |
| **e) Is the patient currently being prescribed any medication? (If yes, please detail medication, dose and reason for use)** |
|  |
| **f) Does the patient have any forensic history (If yes, please provide details)** |
|  |
| **g) Current drug and alcohol use** |
|  |
| **h) Is the patient currently being seen by a local mental health team e.g. CMHT, IAPT, LD?** |
|  |
| **i) Risk and safeguarding concerns:** |
| Suicide Self-harmSelf-neglect | Risk from others Posing risk to others Child protection |  |  | No risks or safeguarding issues |
|  |
|  |
|  |
| **Additional risk and/or safeguarding information:** |

1. **ADDITIONAL NEEDS**

|  |  |
| --- | --- |
| **British sign language interpreter** |  |
| **Step free access/ground floor consulting room** |  |
| **Language translation** |  |
| **Longer appointment** |  |
| **Further information:** |

1. **CONSENT**

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| --- | --- |
| **a) The patient has given consent for the information provided within this referral to be sent to the care provider.** |  |
| **b) The patient has provided consent for the care provider to access the summary/full GP record for the duration of the period of care providing there is a legitimate reason to do so.** |  |
| **c) The referral has been made through a ‘best interest’ decision** |  |

1. **SIGNATURE**

|  |  |
| --- | --- |
| **Referrer Signature:** |  |
| **Date of Referral:** |  |

Please email all referrals to: psicon.assessments@nhs.net

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