**Kent and Medway Complex Autism Service**

The **Kent and Medway Complex Autism service (KAMCAS)** is a commissioned specialist integrated Health & Social Care service which offers an alternative to in-patient, out of area treatment for adults with complex autism and/or behaviour that challenges across Kent and Medway.

Our primary aim is to ensure adults with Autism are able to live within their own communities by preventing admission to secure settings (e.g., hospitals and prisons). We achieve this through providing:

1. Assessment and development of person-centred intervention and support packages
2. Consultation and advice to existing carers, services and support networks
3. Provision of outreach support to individuals with Autism and their support networks within the community (family home, supported living, residential services)

**When the risk of serious harm to self/others or admission to secure services has been reduced, clients will typically be transferred back to secondary services** for any remaining ongoing care and support needs.As such, ***clients should remain open to secondary services for the duration of their support from KAMCAS****.*

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| **KAMCAS acceptance criteria (all 3 must be met):** 1. Individuals who have a primary diagnosis of Autism (without Intellectual Disability).
2. Individuals for whom local social services and health provision have been inadequate to meet their needs.
3. Individuals who are being considered for discharge from hospital or release from prison or unable to retain their place in the community due to significant risk in the medium term (9 months) of:
* Hospitalisation
* Conviction or court disposal
* Suicide or severe harm to self or others
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**Referrals are only accepted from secondary services** (Community Mental Health Teams, Social Services). We cannot accept referrals from GPs. Referrals should be made to the address below (in the footer of this document) by secure email, using this referral form.

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| SECTION A: Client Details |
| 1 | Forename: | Click here to enter text. |
| 2 | Surname: | Click here to enter text. |
| 3 | Date of Birth: | Click here to enter text. |
| 4 | Contact Number/Email: | Click here to enter text.  |
| 5 | Home Address: | Click here to enter text. |
| 6 | Current Address: | Click here to enter text. |
| 7 | Preferred Contact Method: | Click here to enter text. |
| 8 | Gender: | Choose an item. |
| 9 | Pronouns Used: | Click here to enter text.  |
| 10 | NHS Client Number: | Click here to enter text. |
| 11 | Preferred Language: | Click here to enter text. |
| 12 | Ethnicity: | Choose an item. | If other please state: Click here to enter text. |
| 13 | Marital Status: | Choose an item. | If other please state: Click here to enter text. |
| 14 | Religion: | Choose an item. | If other please state: Click here to enter text. |
| 15 | Sexual Orientation: | Choose an item. | If other please state: Click here to enter text. |
| 16 | Emergency Contact Details: | Name: Click here to enter text. Relationship: Click here to enter text. Contact telephone: Click here to enter text.  |
| SECTION B: Referrer Details |
| 1 | Names: | Click here to enter text. |
| 2 | Role: | Click here to enter text. |
| 3 | Team: | Click here to enter text. |
| 4 | Contact Number/Email: | Click here to enter text. |
| 5 | Date of Referral: | Click here to enter text. |
| SECTION C: GP Details |
| 1 | GP Name: | Click here to enter text. |
| 2 | GP Practice: | Click here to enter text. |
| 3 | GP Contact Number/Email: | Click here to enter text. |
| SECTION D: Other Professionals Details |
| 1 | Social Worker: | Click here to enter text. |
|  | Contact Number/Email: | Click here to enter text. | Click here to enter text. |
| 2 | CMHT/CAMHS: | Click here to enter text. |
|  | Contact Number/Email: | Click here to enter text. | Click here to enter text. |
| 3 | Consultant Psychiatrist: | Click here to enter text. |
|  | Contact Number/Email: | Click here to enter text. | Click here to enter text. |
| 4 | Other Key Professionals: | Click here to enter text. |
|  | Contact Number/Email: | Click here to enter text. | Click here to enter text. |
| SECTION E: Additional Information |
| 1 | CCG Area: | Choose an item. |
| SECTION F: Supporting Documentation |
| 1 | Autism Diagnostic Assessment(s):  | [ ]  *N.B. Referrals without a supporting diagnostic assessment report (i.e. original report by diagnosing clinician(s) detailing assessment undertaken) will not be accepted.*Date of ASD diagnosis: Click or tap to enter a date. |
| 2 | Other Diagnostic Assessment(s): |[ ]
| 3 | CPA/CTR Documents: |[ ]
| 4 | Risk Assessment: |[ ]
| 5 | Care & Support Plan: |[ ]
| 6 | Care Act Assessment: |[ ]
| 7 | Discharge Summary: |[ ]
| 8 | Legal Documents: |[ ]
| 9 | Other Clinical Reports: |[ ]
| 10 | Other: |[ ]  Please state: Click here to enter text. |
| SECTION G: Referral Criteria |
| Does the client have a primary diagnosis of Autism? | Choose an item. |
| Does the client have an intellectual disability? | Choose an item. |
| Describe contact with other secondary services and why these services were unable to meet client’s needs. | Click here to enter text. |
| Will the client remain open to secondary services for the duration of their input from KAMCAS? | Choose an item.Name of secondary service(s) remaining involved: Click or tap here to enter text. |
| Confirm if the individual is at risk of losing their current placement, entering secure services, or being discharged into the community. | Click here to enter text. |
| Brief summary of presenting need and reason for referral. | Click here to enter text. |
| Provide a timeline of key risk incidents (i.e. approximate dates and brief summaries of incidents). | Click here to enter text. |
| Has the client consented to this referral?  | Choose an item.If no, please justify: Click here to enter text. |
| View of any carers/advocates/legal representatives  | Click here to enter text. |
| SECTION H: Free Text Area |
| Click here to provide any other relevant information. |