**CYP ASC PATHWAY REFERRAL FORM**

PLEASE EMAIL REFERRAL FORM TO IOWNT.AUTISMPATHWAY@NHS.NET

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| **DETAILS OF CHILD/YOUNG PERSON (CYP)** |
| CYP NAME: | NHS NUMBER: |
| GENDER: | DATE OF BIRTH: |
| ADDRESS:POSTCODE: | SCHOOL/NURSERY:SCHOOL YEAR:KEY PERSON AT SCHOOL: |
| GP & SURGERY: | EDUCATION, HEALTH AND CARE PLAN IN PLACE: Y/N |
| LOOKED AFTER CHILD (BY LA): Y/N | MILITARY FAMILY: Y/N |
| DIAGNOSED MODERATE-SEVERE LEARNING DISABILITY? Y/N |
| **DETAILS OF PARENT/GUARDIAN WITH PARENTAL RESPONSIBILITY** |
| NAME: | TELEPHONE NUMBER: |
| RELATIONSHIP: | MOBILE NUMBER: |
| ADDRESS:POSTCODE: | EMAIL: |
| PREFERRED METHOD OF CONTACT: |
| THE CYP/PARENT/GUARDIAN HAS GIVEN CONSENT FOR THE INFORMATION PROVIDED WITHIN THIS REFERRAL TO BE SENT TO PSICON AND ADDITIONAL SERVICES: Y/N |
| **REFERRER DETAILS** |
| NAME: | PROFESSION: |
| ADDRESS: | CONTACT NUMBER: |
| EMAIL: |
| DATE: | SIGNATURE: |

All referrals requesting ASC assessment for children and young people (CYP) aged 3y – 17y 364d will be discussed at the MDT panel. Where the panel agrees that further ASC screening is indicated, the referral will be forwarded to the provider (Psicon).

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| **OTHER AGENCY INVOLVEMENT** |
|  | CURRENT INVOLVEMENT | PAST INVOLVEMENT | COMMENTS |
| ADHD | [ ]  | [ ]  |  |
| SPEECH & LANGUAGE | [ ]  | [ ]  |  |
| OCCUPATIONAL THERAPY | [ ]  | [ ]  |  |
| PHYSIOTHERAPY | [ ]  | [ ]  |  |
| PAEDIATRICIAN | [ ]  | [ ]  | If current, please provide paediatric individual/team email address: …….. |
| CAMHS | [ ]  | [ ]  |  |
| SOCIAL CARE | [ ]  | [ ]  |  |
| OTHER: …………… | [ ]  | [ ]  |  |
| ARE THERE ANY SAFEGUARDING/SAFETY ISSUES? Y/N | IF YES, PLEASE PROVIDE FURTHER INFORMATION:CIN CP EARLY HELPOTHER:NAME OF SOCIAL WORKER:SOCIAL WORKER CONTACT DETAILS:  |
| **REASON FOR REFERRAL** |
| PLEASE PROVIDE A SUMMARY OF THE REASON FOR ASD REFERRAL/CONCERNS |  |
| HOW LONG HAS THIS BEEN AFFECTING THE CYP AND HOW IS THIS IMPACTING ON DAY TO DAY? |  |
| WHAT SUPPORT IS ALREADY IN PLACE OR WHAT HAS ALREADY BEEN TRIED TO ADDRESS THIS ISSUE? |  |
| WHAT OUTCOME IS HOPED FOR AND WHAT ARE THE CYP/PARENTS’ GOALS? |  |

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| **RISK** |
| REFERRALS FOR CYP WITH MENTAL HEALTH CONCERNS SHOULD BE REFERRED SEPARATELY TO CAMHS OR ANOTHER MENTAL HEALTH SUPPORT SERVICE. THE ASC ASSESSMENT SERVICE DELIVERED BY PSICON IS NOT RESPONSIBLE FOR MONITORING OR MANAGING RISK WHILST A CHILD IS ON A WAITING LIST.PLEASE SELECT ONE OPTION[ ] NO OR LOW RISK THAT DOES NOT REQUIRE ONWARD REFERRAL[ ] RISK OR MENTAL HEALTH CONCERNS HAVE BEEN DISCLOSED AND THE CYP HAS BEEN REFERRED APPROPRIATELY TO: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SUPPORTING INFORMATION** |
| DOES THE CYP HAVE ANY OTHER DIAGNOSIS NOT ALREADY MENTIONED? |  |
| DOES CYP OR PARENT/GUARDIAN HAVE ANY ADDITIOANL NEEDS E.G. STEP FREE ACCESS, HEARING/VISUAL IMPAIRMENTS, ETC.?  |  |
| **FOR 3 AND 4 YEAR OLDS ONLY:**REFERRALS FOR 3 AND 4 YEAR OLDS WILL ONLY BE CONSIDERED WHERE A PAEDIATRICIAN HAS RULED OUT OTHER HEALTH CONDITIONS AND IS SUPPORTIVE OF THE ASSESSMENT, OR WHERE A PAEDIATRICIAN HAS CONFIRMED THERE IS NO REQUIREMENT FOR INVOLVEMENT BUT SUPPORTS AN ASC ASSESSMENT.  | [ ]  CYP HAS BEEN SEEN BY A PAEDIATRICIAN - THEY HAVE BEEN ASSESSED FOR HEALTH CONDITIONS AND SUPPORTS AN ASSESSMENT WITH PSICON[ ]  CYP HAS BEEN REFERRED TO A PAEDIATRICIAN, BUT THEY HAVE CONFIRMED THERE IS NO REQUIREMENT FOR THEIR TEAM TO OFFER AN APPOINTMENT AND SUPPORTS AN ASSESSMENT WITH PSICON[ ]  THIS CYP HAS HAD NO PAEDIATRIC INVOLVEMENT  |
| ANY OTHER RELEVANT INFORMATION |  |