|  |  |  |  |
| --- | --- | --- | --- |
|  | CYP Patient Referral |  |  |
|  |  | |  |
|  | Preamble:  **For your convenience – this form can be completed online via your browser or mobile device at the following link:**  <https://www.theowl.org/hampshire-and-iow/enquiries/>**Completing the form online will streamline the screening process and allow us to minimise referral rejections.**  This form is for new CYP (Age 3y – 17y 11m) referrals to the Hampshire and IoW Autism Spectrum Disorder (ASD) assessment service, managed by The Owl Therapy Centre.  The Owl Centre are only commissioned to undertake ASD assessments, and we are not commissioned to provide mental health support. We are therefore unable to accept referrals where:   * CYP is at risk to themselves, to others or from others.   Please refer all such cases to the relevant Hampshire or Isle of Wight CAMHS for assessment.   |  | | --- | | (*Presents Risk*) Has the CYP been referred to CAMHS for assessment? | | Choose an item. |   CYP aged 3-4 MUST FIRST be referred to the paediatric service for consideration. Failure to do so will result in this referral being rejected.   |  | | --- | | (*Ages 3-4 only*) Has the CYP been considered by the paediatric service? | | Choose an item. |   If the CYP presents with:   * Moderate or severe learning disabilities.   We are unable to accept such referrals. Please make an individual funding request to the ICB. | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **CYP DETAILS (\* indicates a required field)** | | | |
| Forename\* | Click or tap here to enter text. | Surname\* | Click or tap here to enter text. |
| Also known as | Click or tap here to enter text. | Date of Birth\* | Click or tap to enter a date. |
| Pronoun: | Choose an item. | NHS #\* | Click or tap here to enter text. |
| First Line of Address\* | Click or tap here to enter text. | | |
| Second Line of Address | Click or tap here to enter text. | | |
| Post-town\* | Click or tap here to enter text. | | |
| Postcode\* | Click or tap here to enter text. | | |
| Patient Ethnicity\*: | Choose an item. | | |
| Patient Stated Gender Identity\* | Choose an item. | | |
| Gender Identity Same at Birth?\* | Choose an item. | | |
| Is the patient considered to be a CYP? | Choose an item. | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Flags that may affect CYP patient care. Please tick all that apply. | | | |
| Concerning Parent Child Interaction | Worrying Parent Behaviour / Mental Health Concerns | Worrying Child Behaviour | Self-Harm |
| Genital Injury | Referral from Social Services or Police | Previously known to Social Services | Significant injury in child (in the last 12 months) |
| Domestic Abuse | History inconsistent with injuries | Disclosure of abuse | Bullying |
| Delay in Presentation (Children with frequent minor injuries and there is a delay in presentation to medical staff) | Female Genital Mutilation | On Dynamic Support Register | CETR Review |
| Avoid hospital admission | High risk of offending | Treated unfairly due to ASD | Abuse Related to ASD |
| Personally discriminated against due to ASD | In Hospital | Eating difficulties | Homeschooled |
| CIN/CP Plan | Looked after child (LAC) | Special Guardianship order | Moderate/Severe Learning Disability |
| Parentally responsible (recently) active in armed force | Considered Vulnerable | Safeguarding Concern | Homelessness |
| Alcohol Abuse |  |  |  |

|  |  |
| --- | --- |
| 1. Parent/Carer Details ***(\* Indicated required field) – Patient Primary Contact*** | |
| Parent or Guardian Name | Click or tap here to enter text. |
| Relationship to CYP | Choose an item. |
| First Line of Address\* | Click or tap here to enter text. |
| Second Line of Address | Click or tap here to enter text. |
| Post-town\* | Click or tap here to enter text. |
| Postcode\* | Click or tap here to enter text. |
| Contact Email:\* | Click or tap here to enter text. |
| Mobile Number: | Click or tap here to enter text. |
| Home Number: | Click or tap here to enter text. |
| Preferred Communication: | Choose an item. |
| Contact Consent: | Choose an item. |
| 1. Referrer Details (*if not GP)* ***(\* Indicated required field)*** | |
| Referral Source:\* | Choose an item. |
| Referrer Name:\* | Click or tap here to enter text. |
| Job Title: | Click or tap here to enter text. |
| First Line of Address\* | Click or tap here to enter text. |
| Second Line of Address | Click or tap here to enter text. |
| Post-town\* | Click or tap here to enter text. |
| Postcode\* | Click or tap here to enter text. |
| Contact Email:\* | Click or tap here to enter text. |
| Landline Number: | Click or tap here to enter text. |
| Mobile Number | Click or tap here to enter text. |
| Preferred Communication: | Choose an item. |
| Contact Consent: | Choose an item. |

|  |  |
| --- | --- |
| 1. GP Details\* ***(\* Indicated required field)*** | |
| GP Name:\* | Click or tap here to enter text. |
| Surgery Name:\* | Click or tap here to enter text. |
| First Line of Address\* | Click or tap here to enter text. |
| Second Line of Address | Click or tap here to enter text. |
| Post-town\* | Click or tap here to enter text. |
| Postcode\* | Click or tap here to enter text. |
| Contact Email:\* | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Preferred Communication: | Choose an item. |
| Contact Consent: | Choose an item. |
| 1. School/Education ***(\* Indicated required field)*** | |
| Child Homeschooled? | Yes |
| If Yes, Have the LDA been informed?\* | Choose an item. |
| School Name\* | Click or tap here to enter text. |
| First Line of Address\* | Click or tap here to enter text. |
| Second Line of Address | Click or tap here to enter text. |
| Post-town\* | Click or tap here to enter text. |
| Postcode\* | Click or tap here to enter text. |
| Contact Email:\* | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Preferred Communication: | Choose an item. |
| Contact Consent: | Choose an item. |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Other Professionals ***(\* Indicated required field)*** | | | |
| Social Care Worker? | Yes | | |
| If Yes, Name:\* | Click or tap here to enter text. | | |
| First Line of Address\* | Click or tap here to enter text. | | |
| Second Line of Address | Click or tap here to enter text. | | |
| Post-town\* | Click or tap here to enter text. | | |
| Postcode\* | Click or tap here to enter text. | | |
| Contact Email:\* | Click or tap here to enter text. | | |
| Mobile Number: | Click or tap here to enter text. | | |
| Landline: | Click or tap here to enter text. | | |
| Preferred Communication: | Choose an item. | | |
| Contact Consent: | Choose an item. | | |
| Are there Any other professionals involved (current and historic)? | Occupational Therapy | Psychology | CAMHS |
| SALT | Other (Specify): | Click or tap here to enter text. |
| Details of professional involvement: | Click or tap here to enter text. | | |

|  |  |
| --- | --- |
| 1. Risk - Has the CYP: ***(\* Indicated required field)*** | |
| Self-harmed to a degree that has required treatment by a healthcare professional (e.g., stitches)? \* | Choose an item. |
| Self-harmed by head banging, hair pulling, scratching, superficial cutting, or other ways that have not required medical attention?\* | Choose an item. |
| Tried to end their life?\* | Choose an item. |
| Expressed thoughts about ending their life or that they would be better off dead?\* | Choose an item. |
| Engaged in risky behaviour, e.g., use of drink and drugs, theft, or other criminal behaviour?\* | Choose an item. |
| Harmed another person to the extent that person has required treatment by a healthcare professional?\* | Choose an item. |
| **If you have ticked “Within 6 Months” for any of the above, we will be unable to accept the referral. Please refer to Hampshire or Isle of Wight CAMHS. Please also refer all CYPs with mental health concerns alongside suspected ASD to Hampshire or Isle of Wight CAMHS.**    **If in any doubt about mental health presentation or risk, please refer CYP to CAMHS who will consider any co-morbidity.** | |
| If you selected “6+ months ago” for any of the above, please provide details (including whether support was received at the time or if any services were involved/informed) | |
| Click or tap here to enter text. | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Presentation ***(\* Indicated required field)*** | | | | | | |
| Language and conversation\* | ​​Choose an item. | | | | | |
| Does the CYP report having any sensory sensitivities?\* | ​​  Smell | | | Sounds | | Taste |
| Light | | | Textures | |  |
| Detail: Click or tap here to enter text. | | | | | |
| In addition to yourself, has any other professional ever suggested the patient might have ASD?\* | Choose an item. | | | | | |
| Detail: Click or tap here to enter text. | | | | | |
| **Does the CYP show significant signs of the following? (Please select all that apply)** | | | | | | |
| Difficulties with forming and/or maintaining friendships with their peers | | Difficulties with verbal communication e.g. conversations. | | | Difficulties with non-verbal communication (e.g., eye contact, appropriate facial expressions) | |
| Difficulties regulating their emotions to a greater extent than other children their age | | Intense interests which are unusual in content and/or scope | | | Repetitive behaviours (e.g., “stimming”) incl. echolalia | |
| Resistance to change | | Repetitive play | | | Sensory seeking behaviour. | |
| **How do these difficulties present at:** | | | | | | |
| Home:   Click or tap here to enter text. | | | School:  Click or tap here to enter text. | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Supporting Information | | | |
| Please attach any relevant clinical correspondence and reports – important information includes:   * Current/past assessment reports (Neurodevelopmental, OT, SLT, school report etc.) * Copies of reports from previous involvement with CAMHS * GP medical summary   Send completed referral forms alongside supporting documents to:  [hiowicb-hsi.cyp.theowlcentre@nhs.net](mailto:hiowicb-hsi.cyp.theowlcentre@nhs.net?subject=Hampshire%20&%20IoW%20Referral) | | | |
| 1. Indicate any additional needs | | | |
| British sign language interpreter | Choose an item. | | |
| Step free access/ground floor consulting room | Choose an item. | | |
| Interpreter required | Choose an item. | | |
| Hearing impairment | Choose an item. | | |
| Visual impairment | Choose an item. | | |
| Detail: | Click or tap here to enter text. | | |
| 1. Consent ***(\* Indicated required field)*** | | | |
| The CYP/parent/guardian has given consent for the information provided within this referral to be sent to the care provider. | | | Choose an item. |
| The CYP/parent/guardian 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. | | | Choose an item. |
| 1. Signature ***(\* Indicated required field)*** | | | |
| Referrer’s Signature: | | Click or tap here to enter text. | |
| Date of Referral (*dd/mm/yyyy*): | | Click or tap to enter a date. | |