**Isle of Wight ASD Service**

This form should be completed and signed by a health, social care, or education professional.

Psicon accept new referrals for Children and Young People (CYP) aged **3y 0m – 17y 364 days (or up to 18 y 364 d if they have a diagnosis of mild learning disability)** for autism spectrum disorder (ASD) assessment**.**

Referrals for CYP aged 3 and 4 years old will only be considered where a paediatrician has assessed for other health conditions and is supportive of the assessment, OR where a paediatrician has confirmed there is no requirement for involvement by their service and signposted for the referral to be re- directed to Psicon.

Psicon are an assessment only service. Referrals for children with mental health concerns should be referred separately to CAMHS or another mental health support service.

Exclusion Criteria:

* CYP who present with co-morbid mental health difficulties and/or risk to self/others – without input or review from mental health service
* CYP with a moderate to severe learning disability

For this service, please email this referral form (along with any other supporting documentation) to: [kmicb.psicon.childrens@nhs.net](mailto:kmicb.psicon.childrens@nhs.net)

Once Psicon receive the referral, parent/guardian will be invited to carry out the screening process to determine whether the CYP meets the threshold for a full assessment.

1. **CYP DETAILS**

|  |  |  |
| --- | --- | --- |
| **CYP Name:** |  | |
| **NHS Number:** |  | |
| **Date of Birth:** |  | |
| **Gender:** |  | |
| **Ethnicity:** |  | |
| **Full Address:** |  | |
| **Is the CYP:**  **(please tick all that apply)** | Looked after Child/LAC (by local authority)  Under a special guardianship order | Adopted  Not in education/home-schooled  Military Family |
| **Safeguarding/Safety (if applicable)** | Child in Need  Child Protection Plan  Early Help  Please detail: \_\_\_\_\_ |  |
| **Social Worker Details (if applicable)** | Social worker full name:  Social worker team:  Social worker contact details: |  |

1. **PARENT/GUARDIAN DETAILS**

|  |  |
| --- | --- |
| **Parent/Guardian Name:** |  |
| **Relationship to CYP:** |  |
| **Full Address:**  **(if different from above)** |  |
| **Home Number:** |  |
| **Mobile Number:** |  |
| **Contact Email:** |  |
| **Please list names of all parties with parental responsibility and their relationship to the CYP:** |  |

1. **REFERRER DETAILS**

|  |  |
| --- | --- |
| **Name:** |  |
| **Job Title:** |  |
| **Referral Source:** | GP  CAMHS  Paediatric service  Social Worker  School/nursery  Health Visitor  Other (please outline):  Note: Psicon do **not** accept self-referral, or parent referrals. |
| **Address:** |  |
| **Telephone Number:** |  |
| **Contact Email:** |  |

1. **GP DETAILS**

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

1. **PLEASE COMPLETE FOR ALL ASD ASSESSMENT REFERRALS**

|  |  |
| --- | --- |
| 1. **Language and conversation** | Uses full sentences correctly  Speaks in simple phrases (e.g., a 3-word sentence that is not repeating what you have already said)  Speaks in single words  Does not communicate verbally/selectively mute |
| 1. **Does the CYP report having any sensory sensitivities?** | None  Smell  Taste  Light  Textures  Sounds  If yes, please detail: |
| 1. **In addition to yourself, has any other professional ever suggested the patient might have ASD?** | Yes  No  If yes, please detail: |
| 1. **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  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 | |
| 1. **How do these difficulties present at:** | |
| Home:  School/nursery: | |
| 1. **What has led to the CYP/parent/guardian seeking a referral for ASD diagnostic assessment now?** | |
|  | |
| 1. **In what way does the CYP/parent/guardian hope to benefit from an assessment for ASD?** | |
|  | |
| 1. **For CYP aged 3 and 4 only – please select one option** | |
| Paediatric service has seen this referral and confirm its appropriate for Psicon  Paediatric service has not seen this referral | |

1. **RISK**

|  |  |  |  |
| --- | --- | --- | --- |
| **Has the child or young person:** | **Recent/ongoing**  (Within past 6 months) | **Historic**  (6+ months ago) | **Never** |
| 1. Self-harmed to a degree that has required treatment by a healthcare professional (e.g., stitches)? |  |  |  |
| 1. Self-harmed by head banging, hair pulling, scratching, superficial cutting, or other ways that have not required medical attention? |  |  |  |
| 1. Made an attempt to end their life? |  |  |  |
| 1. Expressed thoughts about ending their life or that they would be better off dead? |  |  |  |
| 1. Engaged in risky behaviour, e.g., use of drink and drugs, theft, or other criminal behaviour? |  |  |  |
| 1. Harmed another person to the extent that person has required treatment by a healthcare professional? |  |  |  |
| **Psicon are only commissioned to undertake ASD assessments, and we are not commissioned to provide mental health support. Referrals for children with mental health concerns should be referred separately to CAMHS or another mental health support service. The assessment service is not responsible for monitoring or managing risk whilst a child is on a waiting list.** | | | |
| 1. If you ticked “Recent/ongoing” for any of the above, we will be unable to accept the referral, without confirmation of an appropriate onwards referral where indicated. Please select one option below:   ☐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: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 1. If you selected “Historic” for any of the above, please provide details (including whether support was received at the time or if any services were involved/informed) | | | |

1. **SUPPORTING INFORMATION**

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

* current/past assessment reports (Neurodevelopmental, OT, SLT, etc.)
* copies of reports from previous involvement with CAMHS
* GP medical summary

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Please tick if the CYP has any of the following:** | | | |
| MILD learning disability  MODERATE-SEVERE learning disability  Suspected UNDIAGNOSED learning disability | | Diagnosed ASD  Diagnosed ADHD  Dyslexia  Dyspraxia | |
| 1. **Please describe any diagnoses and/or current concerns regarding the CYP’s mental health:** | | | |
|  | | | |
| 1. **Please list any diagnoses and/or current concerns regarding the CYP’s physical health:** | | | |
|  | | | |
| 1. **Please list any medication prescribed for the CYP (medication name and dose):** | | | |
|  | | | |
| 1. **If applicable, please enter the name of any paediatrician, speech & language therapist, or other healthcare professional/service that the child is being, or has been seen by:** | | | |
| Name of professional/service: | Role/reason for input: | | Date seen from and to: |
|  | | | |
| 1. **If applicable, please detail any relevant information not requested above:** | | | |
|  | | | |

1. **ADDITIONAL NEEDS**

|  |  |  |
| --- | --- | --- |
|  | **CYP** | **Parent/Guardian** |
| **British sign language interpreter** | Yes/No | Yes/No |
| **Step free access/ground floor consulting room** | Yes/No | Yes/No |
| **Interpreter required** | Yes/No | Yes/No |
| **Hearing impairment** | Yes/No | Yes/No |
| **Visual impairment** | Yes/No | Yes/No |
| **Further information:** | | |

1. **CONSENT**

|  |  |
| --- | --- |
| **The CYP/parent/guardian has given consent for the information provided within this referral to be sent to the care provider.** | Yes/No |

1. **SIGNATURE OF PROFESSIONAL**

|  |  |
| --- | --- |
| **Referrer Signature:** |  |
| **Today’s Date/Date of Referral:** |  |

Please note that we are unable to backdate referrals. Referrals will be processed by the date this form is received to [kmccg.psicon.childrens@nhs.net](mailto:kmccg.psicon.childrens@nhs.net)

Psicon handle your personal information in accordance with the Data Protection Act 2018 and the General Data Protection Regulations 2018. We will process personal information in ways that respect your individual rights and in line with our company values, exercising the highest standards of confidentiality, integrity, and trust. For more information, please see the Privacy Notice on our website (bottom left on our home page). You can also request a copy from one of our reception areas or by emailing [enquiries@psicon.co.uk](mailto:enquiries@psicon.co.uk)