bridgecottagesurgery

41 High Street Welwyn Hertfordshire AL6 9EF

www.bridgecottagesurgery.nhs.uk

Tel 01438 715044

general.bridgecottagesurgery@nhs.net

ASD Referral

Dear Parent or Guardian,

We understand that you have made an enquiry about a referral for assessment for autism spectrum disorder (ASD) for your child.

To ensure the referral is done in a timely manner and sent with all the necessary supporting documentation, we ask that you complete the attached forms and bring them with you to your GP appointment. One form needs to be completed by parents/guardians and another form needs to be completed by your child’s school/teacher.

Please note failure to provide all the necessary supporting information may result in a delay in your referral being sent to the appropriate team or the department rejecting the referral.

Please contact us if you have any questions prior to your appointment with the GP.

Yours sincerely,

Bridge Cottage Surgery



|  |  |  |  |
| --- | --- | --- | --- |
| **Hertfordshire Autism Assessment Pre-assessment Information**  **To be completed by Parent/Carer** | | | |
| The information requested on this form is required to process the Autism Assessment referral. By returning the completed form, we assume that you as the parent or carer are consenting to the referral being processed by Hertfordshire Community NHS Trust. | | | |
| Child’s Details | | | |
| Name | |  | |
| DOB | |  | |
| NHS Number | |  | |
| Address | |  | |
|  | |  | |
| Carer’s Details | | | |
| Name | |  | |
| Address if different | |  | |
| Contact Number | |  | |
| Email Address | |  | |
|  | |  | |
| Any reason to consider urgency? (For any risks of suicidal ideation or self-harm, please ask your child to be referred to CAMHS services without delay by your child’s GP) | | | |
|  | | | |
| Please bullet point the main reasons for referral to our services. | | | |
|  | | | |
| Are there concerns at home, school or in both situations? | | | |
|  | | | |
| How old was your child when you became concerned? | | | |
|  | | | |
|  | | | |
| In what way do you hope this assessment will help your child? | | | |
|  | | | |
| **FAMILY HISTORY** | | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Name** | **Age** | **Gender** | **Relationship to child/young person** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | | |
| Does any close family member have the following conditions? If yes, please specify  Neurological disease  Learning problems  ADHD  Autistic spectrum disorder  Mental health problems  Any other significant problem. Please specify: | | | |
|  | | | |
| Developmental Milestones (Please detail if there was any delay or a history of loss of skills) | | | |
|  | | | |
| **COMMUNICATION** | | | |
| Please describe any speech or language difficulties that your child is experiencing now or has had in the past. | | | |
|  | | | |
| Please describe your child’s communication. Comment on who they communicate with, how they communicate, why they communicate – for example: to express their needs, to give information, to share experiences, to have a to and fro conversation. | | | |
|  | | | |
| Please describe any difficulties that your child has with listening, responsiveness, understanding what you have said or following instructions. | | | |
|  | | | |
| Does your child have (tick all that applies) and explain in the box below where necessary  Difficulties understanding humour or sarcasm  Repetitive speech (such as repeating words or phrases of others or from TV)  Unusual characteristics of their communication such as using an unusual  accent, or overly loud or quiet voice or speaking too fast or in an unusual way  Difficulties using non-verbal communication effectively such as a lack of facial  expression, pointing, waving or gesturing or looking awkward while communicating  Lack of, or prolonged, eye contact  A lack of responsiveness to their name being spoken | | | |
| **SOCIAL INTERACTION** | | | |
| How does your child get on with other members of the family? | | | |
|  | | | |
| How does your child get on with other children/young people? | | | |
|  | | | |
| Does your child (tick all that apply) and explain in the box below where necessary  Make and maintain friendships?  Have any close friendships?  Share interest and enjoyment with you or others?  Initiate interaction with others?  Understand the feelings of other people?  Understand how to behave in different situations?  Show concern for others who are hurt or upset?  Show an awareness of social norms such as not criticising teachers,  co-operating with others, showing an interest in current trends? | | | |
|  | | | |
| **PLAY AND IMAGINATION** | | | |
| What does your child like to play with or how do they spend their time? | | | |
|  | | | |
| Does your child show (tick all that applies) and add information in the box below  Unusual aspects to their play?  Lack of pretend play, limited imagination. | | | |
|  | | | |
| Please give details of any intense or unusual interests that your child may have: | | | |
|  | | | |
| Please outline any routines that your child shows a strong preference for or has to follow: | | | |
|  | | | |
| Does your child… (Tick if applies and add information the box below)  Engage in repetitive behaviours or rituals (doing the same thing in a certain way?)  Have difficulty with minor changes in routine? | | | |
|  | | | |
| **SENSORY ISSUES** | | | |
| Is your child excessively sensitive to:  Noise  Smells  The feel of things such as clothes  Does your child show an unusual level of interest in:  Mouthing items  Gazing or looking at items in an unusual way  Touching, spinning or stroking items  Any other (give details) | | | |
|  | | | |
| Please highlight any sensory seeking or avoidant behaviours that your child displays | | | |
|  | | | |
| **MOTOR MANNERISMS** (Stimming or repetitive body movements) | | | |
| Does your child (tick all that apply)  Often walk on their tiptoes or walk in an unusual way  Like to spin themselves around more than other children  Flap their hands or bounce on their feet when excited  Rock themselves  Please outline any repetitive/unusual body movements that your child engages in: | | | |
|  | | | |
| **BIRTH DETAILS** | | | |
| Did you have any health problems during your pregnancy? | | | |
|  | | | |
| Did you take any medication during your pregnancy? (If so, what did you take?) | | | |
|  | | | |
| How long was the pregnancy in weeks (full-term is 37 to 40 weeks). | | | |
|  | | | |
| What was your child’s birth weight? | | | |
|  | | | |
| Any history of post-natal depression? | | | |
|  | | | |
| How was your child delivered and whether they required any after birth care? | | | |
| Labour and delivery (tick all that apply)  Normal C-Section Forceps/Ventouse | | | |
| At or after delivery (tick all that apply)  Resuscitation needed Admitted to special care  Feeding difficulties Postnatal depression | | | |
|  | | | |
| **EARLY DEVELOPMENT** | | | |
| Were any of the following areas of your child’s development of concern to you after birth (tick all that apply)  Gross motor skills – sitting, walking or running  Any regression of gross motor skills  Fine motor skills – picking up and handling toys or cutlery, drawing or cutting  Language - What age did they speak words other than mama and dad?  Any speech regression  Hearing  Eyesight  Self-help skills – dressing, feeding, toileting  Play skills  Imaginative or pretend play skills – copying household activities, dressing up or playing with dolls or teddies small world toys  Aggressive or irritable behaviour  Loss of any skills that they previously had | | | |
| Please outline any concerns about early development here: | | | |
|  | | | |
| **EDUCATION** | | | |
| Name of the preschool/nursery or school attended. Please write home schooled stating the reasons why the child is/was home schooled if applicable. | | | |
|  | | | |
| Please describe difficulties the child experienced during their preschool, nursery or primary or secondary school years as applicable? (Bullying, running away from school, social isolation, poor school attendance etc.) | | | |
|  | | | |
| Please describe any extra support the child received at preschool nursery, primary or secondary school | | | |
|  | | | |
| Is/was the child Home schooled? | | | |
| **MENTAL AND EMOTIONAL WELL-BEING** | | | |
| Please tick against any concerns you have about your child’s emotional well-being | | | |
| Anxiety | Fears or phobias | | Obsessive Compulsive Behaviours |
| Hyperactivity | Hallucinations | | School attendance problems |
| Mood Swings | Eating Disorder | | Anger or aggression and or Involvement with Youth Offending Team |
| Low Mood | Suicidal Ideation | | Domestic Violence |
| Bereavement | Self-Harm | | Drug or Alcohol use or addiction |
| Impulsivity | Short Attention span | | Criminal activity/ antisocial behaviours |
| Has your child ever had treatment (including hospitalisation) by, or is currently seeing, a psychiatrist, psychologist, therapist, or counsellor?  Yes  No    If yes, please give the following details: Nature of the problem; start and end date of support; where seen and clinician’s name; type of support, for example: counselling, play therapy, cognitive behaviour therapy, group work, family work, parent support and advice. | | | |
|  | | | |
| **Previous Assessments**  Please indicate if your child has had any of the following assessments? Please attach copies of any reports and information on support provided.  Paediatric developmental assessment  Educational psychological assessment  Clinical psychological assessment  Speech and language assessment  CAMHS assessment  Occupational Therapy assessment  Children’s Centre  Special Needs Health visitor  Health visitor  Early Years SEN team or Communication and Autism Team(advisory teachers)  SEN Specialist Advice and Support Service  School support including SENCO, TAC (Team Around the Child), parent support, counselling, circle of friends, social support, behaviour support, Pupil Support Base  Social Services including CIN (Child in Need) and CP (Child Protection)  CAMHS Step 2 and Specialist CAMHS  Families First/ Intensive Family Support  Angels/Add-vance/Space/other voluntary agency  Other- Please specify: | | | |
|  | | | |
| **REFERRERS INFORMATION** | | | |
| Name: | | | |
| Relationship to the child: | | | |
| Address if different: | | | |
| Contact Number: | | | |
| Email Address: | | | |

|  |  |
| --- | --- |
| **Hertfordshire Autism Assessment**  **Social-Communication Pre-school/School Questionnaire** | |
| **Childs Details** | |
| **Name** |  |
| **DOB** |  |
| **School** |  |
| **Date of Completion** |  |
| **Name of Person Completing** |  |
| **Title of Person Completing** |  |
|  | |
| **Teachers Concerns (please summarise your main concerns)** | |
|  | |
| 1. **RECIPROCAL SOCIAL INTERACTION** | |
| **Describe his/her use of eye contact in interactions with adults and peers.** | |
|  | |
| **Ability to use facial expression and gesture when communicating. Please tick which applies:**  **Expressive child who uses both facial expression and gesture**  **Rarely uses gesture**  **Limited facial expression**  **Exaggerated/over-dramatic** | |
| |  |  |  | | --- | --- | --- | |  | ***YES*** | ***NO*** | | Is he/she aware of personal boundaries? |  |  | | Does he/she invade others’ personal space or get upset if others invade his/her space? |  |  | | Has he/she established appropriate friendships? |  |  | | Are friendships truly reciprocal? |  |  | | Does he/she dominate interactions? |  |  | | Is he/she on the periphery of interactions? |  |  | | |
| **Can he/she share with adults and/or his peers about things that are happening in his/her life and about his experiences, thoughts and opinions with others?**  **Yes** **No**  **Describe** | |
|  | |
| **Does he/she show interest in others’ experiences, achievements and happiness?**  **Yes**  **No**  **Describe** | |
|  | |
| **Does he/she show sensitivity towards others’ needs and feelings?**  **Yes**  **No**  **Describe** | |
|  | |
| **Is he/she able to cooperate with adults and peers in small group/large class settings?**  **Yes**  **No**  **Can he/she share possessions and activity materials easily?**  **Yes**  **No**  **Describe any difficulties** | |
|  | |
| **Is he/she able to seek help/comfort/reassurance when upset?**  **Yes**  **No** | |
|  | |
| **Does he/she show inappropriate or unexpected displays of emotion:**   |  |  |  |  | | --- | --- | --- | --- | |  | ***YES*** | ***NO*** | **Other** | | Laughs inappropriately |  |  |  | | Angry reaction when corrected |  |  | | Extreme anxiety |  |  |   **Does he/she know how to modify his/her behaviour in different situations in school? e.g. in assembly/playground/ with adults**  **Yes**  **No** | |
|  | |
| 1. **COMMUNICATION** | |
| **Please comment on his/her ability to understand language in the classroom.** | |
|  | |
| |  |  |  | | --- | --- | --- | |  | ***YES*** | ***NO*** | | Is he/she able to express his needs effectively using verbal and non-verbal communication? |  |  | | Is he/she able to express his emotions effectively using verbal and non-verbal communication? |  |  | | Can he/she ask for help? |  |  | | |
| **Describe how he/she copes when there is a problem.** | |
|  | |
| **Is he/she able to initiate and engage in a sustained two way conversation where there is an easy to and fro in the conversation…** | |
| * **With his/her peers? Describe** | |
| * **With adults? Describe** | |
| |  |  |  | | --- | --- | --- | |  | ***YES*** | ***NO*** | | Does the conversation go off at a tangent? |  |  | | Are there obsessive topics? |  |  | | |
|  | |
| **Does he/she have any unusual characteristics in his/her use of language?**  **Unusual accent**  **Monotonous/flat tone**  **Problems with volume or pitch**  **Echolalia (repetition of words)**  **Repetitive phrases**  **Formal pedantic style (e.g. sounds like an adult, corrects what others say, is overly polite)**  **Unusual words** | |
|  | |
| 1. **CREATIVITY/IMAGINATION** | |
| **Does he/she demonstrate a level of creativity/imagination appropriate to peers in the following contexts?** | |
| |  |  |  | | --- | --- | --- | |  | ***YES*** | ***NO*** | | Play |  |  | | Art |  |  | | Written work |  |  | | Reasoning and Problem Solving |  |  | | |
| **Does he/she display any unusual behaviours/unusual interests or preoccupations in play/free-time activities?**  **Yes**  **No**  **Describe** | |
|  | |
| 1. **BEHAVIOUR** | |
| **Does he/she display any repetitive behaviours? Please tick which applies:**  **Collecting**  **Hoarding**  **Spinning Objects**  **Lining up Toys**  **Sorting by colour/shape/size**  **None** | |
| **Does he/she display any hand flapping/finger flicking?**  **Yes**  **No** | |
| **Does he/she have any strong attachments to objects or carry unusual objects in his/her bag or pockets?**  **Yes**  **No**  **Describe** | |
|  | |
| **Does he/she show any unusual interest in the parts of objects rather than the whole object?**   |  |  |  |  | | --- | --- | --- | --- | |  | ***YES*** | ***NO*** | ***Other*** | | Dismantles the object |  |  |  | | Smells objects |  |  | | Feels the object |  |  | | |
|  | |
| **Describe how he/she copes with change to routines.** | |
|  | |
| **Describe how he/she copes with changes to the environment.** | |
|  | |
| **Does he/she insist on particular routines/rituals?**  **Yes**  **No**  **Are you aware of any particular rituals/order that he/she must perform such as always eating snack in a particular order or following the same routine every morning?**  **Describe** | |
|  | |
| 1. **SENSORY PROCESSING** | |
| **Ability to cope with the sensory environment. Please tick which applies:**  **Response to Noise**  **Distracted by noise or covers ears**  **Slow to respond when you speak to them**  **Response to Touch**  **Reacts emotionally or aggressively to touch**  **Difficulty standing in a line**  **Dislikes messy play**  **Response to Movement**  **Seeks movement: fidgets/bounces/jumps/bumps into things**  **Cautious with movement dislikes swing/slides**  **Difficulty climbing stairs**  **Response to Taste/Smell**  **Avoids certain tastes, textures or smells of food**  **Other Behaviours**  **Runs up and down repetitively**  **Walks on tip-toes** | |
| 1. **ACADEMIC PROGRESS** | |
| **A chart with different colored arrows  Description automatically generated with medium confidence**  **Comment on his/her ability to access the curriculum:** | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Area** | **Level** | **Compared to Class** | | | | **< Average** | **Average** | **> Average** | | Reading |  | Bottom  2% / 10% / 25% |  | Top  2% / 10% / 25% | | Writing |  | Bottom  2% / 10% / 25% |  | Top  2% / 10% / 25% | | Maths |  | Bottom  2% / 10% / 25% |  | Top  2% / 10% / 25% | | |
|  | |
| **Describe his/her ability to pay attention in a variety of learning situations** | |
|  | |
| **Can he/she transition from one activity to another without difficulty?**  **Describe any difficulties** | |
|  | |
| **Comment on his/her organisational skills. Does he/she have any difficulties starting or finishing tasks?** | |
|  | |
| **Comment on his/her gross/fine motor skills and handwriting** | |
|  | |
| **Are there any Safeguarding concerns? Is he/she known to children’s services (now or in the past)?** | |
|  | |
| 1. **OTHER RELEVANT INFORMATION** | |
| **Does he/she require additional support within school? Please tick which applies:** | |
| **Has a Classroom Assistant?**  **Part-Time**  **Full-Time**  **No** | |
| **Has an EHCP?**  **Yes**  **No** | |
| **What Additional support is in place (including social skills training)?** | |
|  | |
| **Receives outreach support?**  **Yes**  **No**  **If Yes, from:** | |
|  | |
| **Referred to Educational Psychologist?**  **Yes**  **No**  **If Yes, date of referral:** | |
|  | |
| **Known to Educational Psychologist?**  **Yes**  **No**  ***(If Yes, please attach a copy of the report)*** | |
| **Is an Assess, Plan, Do, Review plan in place?**  **Yes**  **No**  ***(If Yes, please attach a copy)*** | |
| **Please attach:**   * **a relevant sample of school work (e.g. an essay).** * **an ‘Early Years Function’ report, if appropriate.** | |
| **THANK YOU FOR COMPLETING THIS FORM** | |