**HUMBER NHS TEACHING FOUNDATION TRUST**



**Humber Adult Autism Diagnostic Service (HAADS)**

**Referral Form**

|  |
| --- |
| Autism Spectrum Disorder (ASD) is a developmental disorder of variable severity that is characterised by difficulty in social interaction, social communication and by restricted or repetitive patterns of thought and behaviour. Please be aware this is currently a diagnosis only service.Referral criteria:* The person must be aged 18 or over (unless transition agreement)
* The person must be registered with a Hull or East Riding of Yorkshire GP
* Referrals must be completed by a qualified medical or allied health professional who has some evidence the person may be autistic
* The referral must contain evidence of ASD related symptoms, and how these are affecting function in day to day life
* It is the opinion of the referrer that the potential traits are having a significant impact on the person’s health and/or well being
* Informed consent has been gained prior to the referral being made

**Please note incomplete referrals will be returned for more information.**  |
| **Referred Person’s Demographic Details** |
| Surname(alias/previous name): Click here to enter text. | Forename/s: Click here to enter text. |
| Title: Choose an item. | Sex:Male [ ]  Female [ ]  Other: Click here to enter text. | Date of Birth:Click here to enter a date. |
| Address:Click here to enter text. | Town: Click here to enter text. |
| County: Click here to enter text. | Postcode:Click here to enter text. | Telephone Number:Click here to enter text. |
| **Marital status (tick relevant box)** |
| [ ] Single [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed  |
| **Please state ethnicity:** Click here to enter text. |
| **NHS Number:**  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Referred Person’s General Practitioner (GP)** |
| Initial: Click here to enter text. | Surname: Click here to enter text. | Surgery address: Click here to enter text. | Telephone No:Click here to enter text. |
| **Referral Details** |
| Name of Referrer: Click here to enter text. | Designation: Click here to enter text. |
| Date of referral: Click here to enter a date. | External referral [ ]  Internal referral (from Humber FT) [ ]   |
| **Digital Consent**  |
| HAADS requires consent to contact patients via email or text. If the patient does not consent please indicate here. | **Does not** consent to digital contact [ ]  Patients email address:Click here to enter text. |
| **Please provide evidence of ASD traits and how it affects the individual in all 3 areas where possible.** ***Please note insufficient information will result in the referral being returned.*** Please use the tick boxes and also add additional information. Please include a narrative description of the patient as well as ticking the boxes  |
| 1. ***Social Communication***
 |
| [ ] Difficulty with verbal and non-verbal communication (avoiding eye contact/difficulty understanding facial expressions)[ ] Difficulty starting/maintaining/give-and-take conversations, literal understanding of language, difficulty understanding jokes/sarcasm **Further Information:** Click here to enter text. |
| 1. ***Social Interaction***
 |
| [ ] Difficultly understanding others’ emotions/point of view[ ] Difficultly fitting in socially[ ] Difficulty initiating and maintaining relationships[ ] Finding people confusing/unpredictable**Further Information:** Click here to enter text. |
| 1. ***(a) Routines/rituals (b) Highly focused and intense interests (c) sensory sensitivities***
 |
| [ ] Fixed daily routines[ ] Uncomfortable with change, cope better with preparation[ ] Intense interest in specific, highly focused areas of interest[ ] Hyper/hyposensitive to one or more senses**Further Information:** Click here to enter text. |
| **Current Functional Difficulties**Please outline how the above traits are currently impacting on the individuals life e.g. affecting relationships, accessing education, employment |
| Click here to enter text. |

|  |
| --- |
| **Risk Assessment** |
| **Current and potential risk to self (e.g. suicide ideation/intent, self-injurious behaviour, substance misuse) and/or social risk (e.g. risk to employment/educational achievement, living arrangements)**Click here to enter text. |
| **Current and Potential Risk to Others (e.g. aggression/violence, abusive behaviour)**Click here to enter text. |
| **Risk Alerts**  | **Yes/No/Not known** |
| Would the person pose a risk to staff? | Choose an item. |
| Would a family member pose a risk to staff? | Choose an item. |
| Is a joint visit / work necessary? | Choose an item. |
| Should the person only be seen at a team base / clinic? | Choose an item. |
| Is the gender of staff an issue? | Choose an item. |
| Are there any other known risks to be considered?Click here to enter text. |
| Is client aware of the referral: [ ]  YES [ ]  NOHas the person consented to this referral [ ]  YES [ ]  NO*or if lacks the capacity,*Has the referral been made within the person’s best interest [ ]  YES [ ]  NO |
| Other Agencies/Professionals involved:Click here to enter text. |

**Sending Options:**

* **Distribute via SystmOne**
* **Email securely to:** **hnf-tr.haads@nhs.net**
* **Post to Humber Adult Autism Service**

 **298 Townend Court**

 **Cottingham Road**

**Hull**

 **HU6 8QR**

If you have any further questions, please contact the team on01482 336740 or email hnf-tr.haads@nhs.net