Standardised Referral Form

Belfast Health and Social Care Trust

Referral to the Adult Autism Spectrum Disorder Diagnostic Service
The Adult Autism Spectrum Disorder Diagnostic Service accepts referrals of individuals from the age of 18 years who present with signs which suggest that they may fall within the Autism Spectrum and have difficulties functioning. Referrals which fail to meet the specified criteria will be declined. Please note that referrals for assessment can be accepted only where the purpose of the referral (i.e. assessment for Autism Spectrum Disorder) has been fully discussed with the client and consent has been agreed. Please √ to confirm this has been done. Yes ☐ No ☐ Also, please √ if known to Trust Services Yes ☐ No ☐

Personal Information	
Name:	D.O.B:
Age:	Gender:
Language(s) spoken at home:	
Full Address (With Postcode):	Telephone number:
Contact Person(s) and Relationship to Client: (if applicable) Telephone number:	
General Practitioner: Telephone number: Surgery Address: Postcode:	
Reason for Referral (specific concerns to be provided overleaf: (Note any reasons why clarification of a possible ASD Diagnosis is likely to be helpful)	

Professionals / Agencies Involved	
Professionals/Agencies CURRENTLY Involved	Professionals/Agencies PREVIOUSLY Involved
Daycare/School/Education/Work/Training CURRENTLY Involved	Previous School/ Educational Attainments Any Statement of Special Educational Needs?

Risk Assessment:

	Past	Current		Past	Current	Additional comment on risk:
Self Harm			Alcohol abuse			
Suicidal Ideation			Forensic			
Neglect			Aggression			
Drug Abuse			Violence			

Please state specific concerns/possible indications of ASD:
Development: Was there evidence of any developmental delay? Were all developmental milestones achieved? Please provide details if available:

Communication ability: (e.g. Level of understanding/expressive language; non verbal communication; unusual characteristics of communication)

Quality of social functioning / social interaction with family / peers / strangers:

Concerns re: restricted interests/leisure activities:

Activities of daily living: (e.g. degree of independence, awareness of danger)

Behavioural concerns: (e.g. poor sleep; dietary concerns; aggression/self harm; obsessive behaviours; coping with change)

Psychological / Medical / additional needs: (to include co-morbid concerns and medication)

Other information e.g. (list any issues or concerns that might potentially influence the assessment):

Referred by:	
Name: Address: Signature: _____	Profession: Telephone number: Date: _____
Please return completed form to: Adult Autism Diagnostic team, Elmwood Manse, 7 University Terrace, Belfast BT7 1NP	

Date Received: _____ System Logged: _____

Health and Care Number: _____

Link to RASDN Autism Adult Care Pathway PDF :
http://www.hscbusiness.hscni.net/pdf/Adult_Care_PAthway_Reviewed_August_2013.pdf