Date Received: ..... PARIS Logged: ..... PARIS ref number .....

Belfast Health and Social Care Trust

Autism Assessment and Diagnostic Service
REFERRAL FORM

Referral for an Autism assessment must be discussed with the person with parental responsibility and consent obtained. All sections must be completed in BLOCK CAPITALS (unless typed).

Child's Name: _____ DOB: _____

Address: _____ Post Code:_____

Person with parental responsibility Name: _____ Relationship _____

Address: _____ Post Code: _____
(If Different from Child)
Telephone No. Home: _____ Work: _____ Mobile: _____ _____

E-mail address _____

Language(s) spoken at home: *(including BSL)*_____

Is an interpreter required for parent and/or child? ☐ **Yes** ☐ **No**

Which language? _____

Does the person with parental responsibility understand written English? ☐ **Yes** ☐ **No** ☐ **Don't Know**

GP: _____ Tel No: _____

Address / Surgery: _____

School/Nursery: _____ Tel No: _____

Address: _____

Professionals currently involved with the child? *please tick and provide name & contact details if known.*

☐ Health Visitor:
☐ SLT:
☐ Paediatrician:
☐ OT:
☐ CAMHS :
☐ Physio:
☐ Ed. Psych:
☐ CIDS
☐ Social Worker:
☐ Oakwood Service
☐ Sure Start.*please specify*
Others, *please list*

Relevant professional reports should be attached to this referral form and/or forwarded.

Why are you making this referral at this time?

Please state specific concerns under the following headings: ***PLEASE GIVE SUFFICIENT DETAIL UNDER EACH SECTION OR THE REFERRAL MAY NOT BE ACCETPED.***

Development: Is there evidence of any developmental delays? ☐ **Yes** ☐ **No**

If yes, please specify: (e.g. sitting, crawling, walking, babbling, language, feeding)

Does the child have a statement of special educational needs
OR is in the process of being assessed? ☐ **Yes** ☐ **No**

Communication ability:

☐Difficulties with comprehension including literal interpretation, humour, sarcasm

☐Delay or absence of spoken language

☐Repetitive speech or echolalia (Repeats words or phrases of others or from TV)

☐Unusual characteristics of communication (i.e. accent, intonation, vocabulary)

☐Impairment in non verbal communication (i.e. facial expressions, no gestures, no pointing or waving by 12 months)

☐Lack of, or prolonged eye contact

☐Inconsistent response to name

Quality of social interaction with family/ peers/ strangers:

PLEASE GIVE SUFFICIENT DETAIL UNDER EACH SECTION TICKED FOR THIS CHILD TO BE TRIAGED

☐ Limited interest in typical play and or play with peers

☐Unable to share interests or pleasures

☐Not responsive to other peoples facial expressions, feelings, lack of empathy

☐Lack of awareness of social norms (i.e. criticising teachers, unwillingness to cooperate, inability to follow current trends)

☐Failure to relate normally to adults (too intense / no relationships)

Concerns re. play/ interests/ behaviours:

PLEASE GIVE SUFFICIENT DETAIL UNDER EACH SECTION TICKED FOR THIS CHILD TO BE TRIAGED

☐Lack of pretend play, limited imagination, abnormal intense interests, unusual play

☐Difficulties with minor changes of routine

☐Difficulties with minor changes of environment

☐Rituals that have to be performed in a certain way

Sensory concerns: (e.g. overly sensitive or lack of response to touch, sound, vision, smell, taste, movement/balance)

Behavioural concerns: (e.g. poor sleep; dietary concerns; aggression/self harm; danger awareness)

Activities of Daily Living:

☐ Independence with personal care (e.g. toileting, washing, dressing, eating)

☐ Organisational skills at home and school

☐ Concerns with fine or gross motor skills

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

Educational concerns if known:

Parent/carer concerns:

REFERRER DECLARATION

I HAVE DISCUSSED MY CONCERNS WITH THE PARENTS/CARERS AND THEY HAVE AGREED TO THIS REFERRAL. CONSENT FOR REQUEST OF ADDITIONAL RELEVANT REPORTS TO SUPPORT THE ASSESSMENT PROCESS HAS BEEN OBTAINED.

Referred by:

Name: _____ Date: _____

Address: _____ Tel No: _____

Profession: _____

Referrer Signature **Parental Consent Signature**

Please return completed form to:

Autism Assessment and Intervention Service
Carlisle Centre
2nd Floor
40 Antrim Road
Belfast BT15 2AX