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**ASD Assessment Referral Form for GPs – NHS Patient Choice**

**Details of Young Person:**

Full Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
Address:	<input type="text"/>	Gender:	<input type="text"/>
		Language spoken:	<input type="text"/>
NHS Number:	<input type="text"/>	Ethnicity:	<input type="text"/>
Registered GP and Practice Address:	<input type="text"/>		

**Educational History:**

Name of Current School or College:	<input type="text"/>		
School Address:	<input type="text"/>	Telephone No:	<input type="text"/>
		Name of preferred contact:	<input type="text"/>

Names of previous nurseries, schools and colleges attended:

1.	<input type="text"/>	Dates attended:	<input type="text"/>
2.	<input type="text"/>	Dates attended:	<input type="text"/>
3.	<input type="text"/>	Dates attended:	<input type="text"/>
4.	<input type="text"/>	Dates attended:	<input type="text"/>



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**Details of Parents/Carers:**

Who has parental responsibility?

Name(s):	<input type="text"/>	Relationship to Young Person:	<input type="text"/>
	<input type="text"/>	Relationship to Young Person:	<input type="text"/>

Contact Details for Parents/Carers:

Telephone Number:	Number belongs to:	Consent for us to leave voicemail:
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes, can leave voicemail
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes, can leave voicemail
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes, can leave voicemail

Email Address:

Address — if same as above (please tick):

If parent(s) have a different address to the young person, please provide details below:

Address (if different):

Please can you tell us a little bit about the young person and any general concerns you may have about their behaviour, social abilities, development or mental health?



Has the young person received or are they awaiting assessment for any of the following formal diagnoses (please tick as required and provide details below if they are awaiting assessment):

- |  |                          |                             |                          |
|--|--------------------------|-----------------------------|--------------------------|
| ADHD .....                                       | <input type="checkbox"/> | Neurofibromatosis .....     | <input type="checkbox"/> |
| Learning/Intellectual Disability .....           | <input type="checkbox"/> | Muscular Dystrophy .....    | <input type="checkbox"/> |
| Specific Learning Difficulty (e.g. dyslexia) ... | <input type="checkbox"/> | Epilepsy .....              | <input type="checkbox"/> |
| A Speech and Language Disorder .....             | <input type="checkbox"/> | Genetic abnormalities ..... | <input type="checkbox"/> |
| Developmental Coordination Disorder .....        | <input type="checkbox"/> | Hearing Impairment .....    | <input type="checkbox"/> |
| Fragile X Syndrome .....                         | <input type="checkbox"/> | Sight Impairment .....      | <input type="checkbox"/> |
| Tuberous Sclerosis .....                         | <input type="checkbox"/> | Psychiatric Disorder .....  | <input type="checkbox"/> |

Additional details (optional):

Are there any members of the young person's close or extended family who have already received a formal diagnosis of Autism Spectrum Condition/Disorder or Asperger's Syndrome?

- Yes     No     Unknown

If Yes, please provide details:

Are there other professional services involved in the care of the young person? (e.g. Paediatrics, SALT, OT)

Does the young person have any formal support in school currently?



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Has the young person ever undergone an assessment for autism-spectrum disorder in the past or are they awaiting an autism-spectrum disorder assessment within another service?

Has the young person or their family ever received involvement from Social Care or mental health services? (if yes, please provide further information, including whether there is any ongoing service involvement).

**CONSENT – Please tick to confirm the following:**

- An individual with parental responsibility consents to involvement from DAISY Psychology Services as part of NHS Patient Choice.
- Young people aged 16 years and older, who are deemed to have capacity, consent to involvement from DAISY Psychology Services as part of NHS Patient Choice.
- Consent is given to the sharing and requesting of information from other services for assessment purposes, including written questionnaires being sent to the young person’s educational establishment.

**Please send this completed form, with the ‘Social Communication Questionnaire – Parent/Carer Version’, to our secure email address: [info@daisypsychology.org](mailto:info@daisypsychology.org)**