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**Adult Autism Referral Form**

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| **Inclusion criteria for ASD assessment** |
| We are only able to accept referrals that meet the following criteria:   * Aged 16+ in Birmingham and 18+ in Solihull * Registered to a GP in Birmingham or Solihull as defined by BSol criteria * **AQ10** score **of 6 or above**. Referrals below this score **will not** be processed * Features are indicative of Autism Spectrum Disorder in accordance with the ICD-11 criteria * Characteristics of ASD or concerns have been present from childhood * No existing diagnosis of significant learning disability |
| Please email your completed form to the single point of access at **AdultASDConnect@stah.org** |

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| **Patient Contact Details & Address**  *It is important that the referral team is notified immediately of any change in contact details. Failure to do so may result in a closed case.* | | | |
| Patient Name & Title: |  | | |
| Date of Birth: |  | NHS Number: |  |
| Patient Address: |  |  |  |
| Mobile Number: |  | | |
| Landline Number: |  | | |
| Email:  **Please note assessment information is gathered online therefore an email address is required** |  | | |

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| **Referrer Details**  *It is important that the patient reports any change in GP to the referral team. Failure to do so may result in a closed case.* | | | |
| Name of person making the referral: |  | | |
| Role and Organisation: |  | | |
| Referral Date: |  | | |
| GP Name: |  | | |
| GP Surgery: |  | | |
| Address: |  | | |
| GP Practice: | Birmingham GP 🞏  Solihull GP 🞏 | | |
| Email Address: |  | Practice Code: |  |

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| **Referral for Autism Assessment**  Please consider the ICD-11 criteria when providing evidence:   * Persistent deficits in initiating and sustaining social communication and reciprocal social interactions. * Persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are clearly atypical or excessive for the individual’s age and sociocultural context. * The onset of the disorder occurs during the developmental period, typically in early childhood. * The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. | |
| Please provide a summary of features and difficulties: | |
| Have these difficulties been present since early childhood? | Yes 🞏 No 🞏 Unknown 🞏 |
| Have the difficulties noted in this referral been recognised by any of the following: | Family Members 🞏  Friends 🞏  Work/Employers 🞏  School/Education Provider 🞏  Unknown 🞏 |

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| Does the patient have a learning difficulty or learning disability? | Yes 🞏 No 🞏 |
| If yes, does the patient have an IQ >70?  If unknown please estimate (for example have they received specialist SEND support in school) |  |

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| Past Medical History relevant to referral |
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| Are there any known risk issues identified? |
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| Are there any other diagnoses in place? Are there any other services involved? |
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| **Consent** | |
| Has the patient consented to this referral? | Yes 🞏 No 🞏 |
| Does the patient consent for us to share information about this referral with any other person?  If yes, please provide their details below: | Yes 🞏 No 🞏 |
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| **Checklist** |
| Referral Form enclosed 🞏  AQ10 enclosed 🞏  AQ10 Score: \_\_\_\_  **(The referral will not be accepted if the total score is not provided)** |

**Please email ALL of the required completed documentation to:** [**AdultASDConnect@stah.org**](mailto:AdultASDConnect@stah.org)