Complex Health Needs Service
Ash House
St Martin's Hospital
Clara Cross Lane
Bath
BA2 5RP

Tel: 01225 831566
Fax: 01225 833813

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AUTISTIC SPECTRUM SERVICE REFERRAL FORM

NAME		**DATE OF BIRTH**	
CAREFIRST ID			
ADDRESS		**ETHNIC ORIGIN**	
POSTCODE		**TEL NO**	
GP **TEL NO** **PRACTICE**		**CASE MANAGER** **TEL NO** **TEAM**	
N.O.K NAME: CONTACT DETAILS:		**CARER'S DETAILS** NAME: CONTACT DETAILS:	

Has this person been diagnosed with an autistic spectrum condition?

Yes ☐ No ☐

*__If yes please provide evidence of the diagnosis (copy of report etc.)__

Client's Preferred Method of Communication

How do you help him/her to understand what is said?

How does he/she tell you what they want to say?

Why are you making this referral?
What would you like from this referral?
Summary of Needs and Risk Factors

Referrer/Organisation:		Tel No:	Referral Date
Client's Consent to Referral and the potential for the sharing of information within the team Yes ☐ No ☐ ☐ unable to consent (e.g. lacks capacity)		If NO, why not?	

Medical History: (Including: primary cause of disability, major illnesses, operations, hospital admissions, emotional distress, psychiatric illness, behavioural distress, epilepsy, special dietary needs)

CURRENT SERVICES RECEIVED (e.g., day placement, education, respite, etc.) PLEASE INCLUDE ALL CONTACT NAMES AND TELEPHONE NUMBERS.

	am	pm	eve
Mon			
Tues			
Wed			
Thurs			
Fri			
Sat			
Sun			

Complex Health Needs Service Professional Involved (Tick (✓) and name)

Consultant Psychiatrist	Occupational Therapist
Clinical Psychologist	Physiotherapist
Community/Behavioural Nurse	Speech & Language Therapist
Hearing Therapist	Care Manager/Social Worker

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Date of Discussion: *Team Discussion:*	*Action:*

Consent and potential for sharing of information discussed with client at initial visit. Yes ☐ No ☐

REFERRAL ACCEPTED BY:	DATE: / /