**Request for Assessment Form (ASC1)**

**Autism Spectrum Disorder**

**Assessment Team (ASDAT)**

Community Paediatrics

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| **This form is to be** **completed by a person working with the child, young person or family in a professional capacity. Self-referrals and parental referrals will not be considered.****If this child is already under the care of a Community Paediatrician, please discuss your concerns with the doctor prior to making this request for assessment.** |

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| **Child’s Details** |
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| **Child’s name** |  | **Home address *Inc. Postcode.*** |
| **Date of birth** |  | **NHS number / UN** |  |  |
| **Gender at birth** |  | **Also known as***Do not use for adopted children.* |  |

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| **Referrer Details (Person completing this form and coordinating this referral)** |
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| **Name (Full)** |  | **Job Title** |  |
| **Agency / Organisation** |  | **Contact Numbers** |  |
| **Correspondence Address** |  |
| **Email Address** ***(Works only)*** |  |

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| **Parent / Carer Contacts** |
| \*Please note, if two adults are identified as having legal PR and live at two different addresses, a parent/carer questionnaire should be completed by both.

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| **Full Name**  | **Address** **(if different from above)** | **Contact** **number** | **Relationship to child** | **Parental Responsibility for the child? Y/N** |
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| **Details of education setting, early years provision or childminders.** |
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| **Setting name** |  | **Contact Name** **(i.e. SENDCo)** |  |
| **Address** |  | **Contact Number:****Email Address:** |  |

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| **Details of registered GP** |
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| **Practice Name** |  | **Contact number** |  |
| **Practice Address** |  |

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| **Key Information** |
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| **Is this for a looked after or adopted child?** | Unsure[ ]  Yes [ ]  No [ ]  |
| **Is this child subject to a child protection or CIN plan?** *If yes, please give details below.* | Unsure[ ]  Yes [ ]  No [ ]  |
| **Are there any current safeguarding concerns?** *If yes, please give details below.* | Unsure[ ]  Yes [ ]  No [ ]  |
| **Is an interpreter required?** | Yes [ ]  No [ ]  Language: |
| **Please provide further information if you have answered yes to any of the above.** |  |

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| **Summary of why an assessment is being requested (your concerns/observations)** |
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| **Is there a known history of any Adverse Childhood Experiences (ACEs)?** *Please give details.* |
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| **What happens next?** |
| 1. Parent / Carer / Young Person (16+) to read and sign the consent form (ASC2)
2. Form ASC3 to be given to parent/carer to complete
3. Form ASC4 to be given to nursery, school or collage to complete.
4. All forms to be returned to the ‘referrer’ (the person completing ASC1) for submission.
5. The referrer then completes the submission log (at the end of this form) and ensures all four forms (ASC1, ASC2, ASC3, ASC4) are sent electronically to the assessment team at Barnsley.ASDAT@nhs.net
* Incomplete forms, part submissions and self-referrals will all be returned to the referrer without consideration.
* **Once the completed referral pack has been received, it will be triaged by a paediatrician using the information provided.**
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| **Submission form***To be completed at the point of submission by the ‘referrer’**Please do not submit the referral pack until you are able to answer ‘yes’ to all the following points.* |
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| ***The Minimum Criteria for referral are achieved:*** | *Yes / No* |
| *1: Child is under the age of 18* |  |
| *2: Child is registered with a Barnsley commissioned GP* |  |
| *3: An Early Help Assessment (EHA) is open and at least one review cycle has taken place*  |  |
| *4: This child has not been previously assessed or significant new evidence is available since previous assessment* |  |
| *5: There is evidence of social communication difficulties.* |  |
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| ***The required paperwork is completed and included in this submission*** | *Yes/No* |
| *1: Request for assessment form (ASC1) [Mandatory]* |  |
| *2: Consent form (ASC2) [Mandatory]* |  |
| *3: Parent/carer information form (ASC3) [Mandatory]* |  |
| *4: Education information form (ASC4) [Mandatory] and / or (ASC00) [Optional]* |  |
| *5: Supporting information form [Optional]* |  |
| *6: Copy of latest EHA review paperwork [Preferred]* |  |
| ***Date of submission:***  |
| ***NOTE:*** *ANY INCOMPLETE OR OMITTED PAPERWORK WILL BE RETURNED TO THE PERSON COMPLETING THIS FORM (ASC0) FOR FURTHER ACTION* |