**Referral form for the Sheffield Adult Autism Service**

***Eligibility Criteria***

**We will only be able to accept referrals that meet the following criteria.**

**(Please tick to confirm):**

**Seeking a diagnostic assessment or post-diagnostic support for ASD**

**Individual aged 16 years and above**

**No diagnosis of a Learning Disability/Intellectual disability (intellectual developmental disorder)/Global developmental delay.**

**BMI above 15 –** meaning the person is not severely underweight and subject to the effects of starvation (which would affect the validity of our assessment), to your knowledge.

**No current diagnosis of dementia -** and is not going through the diagnostic process for dementia.

**Person has given informed consent to the referral.**

**Referral has been completed by a GP or other health professional.**

**If referring for a diagnostic assessment, the person has not already been assessed for autism**

* We are unable to accept self-referrals.
* We are unable to expedite referrals under any circumstances, due to high demand for our service. In the event of deterioration in an individual’s mental health whilst waiting for an assessment, we would recommend they contact their local mental health crisis service or are referred to their local mental health service for further assessment.
* We are unable to accept referrals for assessments to revoke a diagnosis of autism, or to complete a second-opinion assessment.
* Our website contains useful information and resources about managing autism symptoms which may also be helpful while awaiting an assessment (<https://www.shsc.nhs.uk/services/sheffield-adult-autism-and-neurodevelopmental-service>).
* For referrals from CAMHS/Ryegate Children’s services, please complete SAANS transitions referral form instead (Nb: referral must have been discussed in the relevant transitions meeting).
* **For us to process this referral effectively, please include as much detail as possible.**

|  |
| --- |
| Client Name:  Date of Birth:  NHS Number:  Address:  Telephone:  E-mail address:  Does the person agree to receiving text reminders for their appointments?  Yes (please ensure mobile number is provided)  No |
| If the client finds it difficult to communicate via telephone or other methods, they can provide consent for another person to speak to SAANS staff / arrange appointments on their behalf.  Please note, without consent we will not discuss the client’s care with any other person.  Name:  Relationship to client:  Contact details:   * Telephone number: * Email address:   Client Signature to confirm consent: |
| Referral for:  ASD diagnostic assessment *Please complete all of Section 1*  **If the person is requesting an ASD diagnostic assessment with SAANS using their NHS Right to Choose, please provide confirmation of this.**  ASD post-diagnostic support **(Sheffield GP only)** *Please complete all of section 2.*  **For people with an existing diagnosis of ASD we can offer our Understanding autism psychoeducation group.**  **Before we can accept a referral for the group, we would require evidence of ASD diagnosis if this was not completed by our service (e.g., diagnostic report).**  **For some individuals not suitable for the group, we may offer time-limited 1-1 support, where their core difficulties are related to autism. For us to adequately triage your referral, please include details of the referral reason and client’s goals in section 2.**  **We can also offer advice and consultation to other health professionals regarding autism, which can be accessed via emailing:** [**saansclinicalqueries@shsc.nhs.uk**](mailto:saansclinicalqueries@shsc.nhs.uk) |
| Referrer details:   * Referrer Name: * Referrer Profession: * Service name and address: |
| Employment/education status (of person being referred) |
| Please list any co-occurring or previous mental health conditions and list **history** of involvement with mental health services. |
| Is the person **currently** receiving support from any other services? E.g., mental health services, social support, or physical health services? |
| Please state risk status of the person:  **This section must be completed.**  Risk to self  Current  Yes  No  Historical  Yes  No  Details  Risk to others (including staff)  Current  Yes  No  Historical  Yes  No  Details  Risk from others  Current  Yes  No  Historical  Yes  No  Details |
| **Section 1 Request for Diagnostic Assessment** |
| Summary of difficulties  1) Social Communication  Difficulty with verbal and non-verbal communication (avoiding eye contact/difficulty  understanding facial expressions)  Difficulty starting/maintaining/give-and-take of conversation, literal understanding of language, difficulty understanding jokes/sarcasm.  Please give further details: |
| 2) Social interaction  Difficulty understanding other’s emotions/point of view.  Difficulty fitting in socially  Difficulty initiating and maintaining relationships.  Preferring to spend time alone, finding people confusing/unpredictable.  Other:  Please give further details: |
| 3) a) Routines/Rituals; b) Highly focussed and intense interests  Fixed daily routines.  Uncomfortable with change, cope better with preparation  Intense interest in specific, highly focussed areas of interest  Other:  Please give further details: |
| 4) Sensory processing difficulties  High sensitivity to sounds/tastes/smells/visual stimuli e.g., can sense things others cannot.  Low sensitivity to sounds/tastes/smells/visual stimuli e.g., cannot sense things that others can.  Other:  Please give further details: |
| Have the above difficulties been present since childhood? If so, what age were they noticed? |
| Do these difficulties cause a significant impairment in this person’s ability to function? Please describe. |
| What does the person hope to get out of the assessment/what are their goals? |
| **Section 2 Request for post-diagnostic support** |
| When and where was the person diagnosed?  Please attach a copy of the diagnostic report (if not diagnosed by our service) |
| What support is being requested?  (Our usual pathway is to attend our understanding autism group before looking at other support so please indicate if the individual consents to attending a group) |
| Has the person received support for autism previously? If so, please give details: |

**Please return to:**

SAANS or saans@shsc.nhs.uk

Michael Carlisle Centre

75 Osborne Road

Sheffield

S11 9BF