INTEGRATED AUTISM SERVICE
REQUEST FOR ASSESSMENT OF AUTISM

Service user details:		
Name:	Title:	DOB:
Preferred name:		
Address:		NHS number (if known):
		M number (if known):
Email:		Phone:
Preferred language:	Ethnicity:	Gender:
Culturally important information:	Employment status:	Date of referral:
Referrer details (If self-referral, please leave this section blank):		
Name:		Date of referral:
Address:		Profession/Role:
		Phone: Email address :
Relationship to person seeking assessment:		
Have you discussed the referral with the person? Y ☐ N ☐ Please note, referrals will not be accepted without informed consent. Please advise the client that the IAS are a multi-agency team so information may be accessed by both local authority and health staff.		
GP details (if not referrer):		
Name :	Phone:	
Address :	Email address :	

Other Professionals involved:

	Name	Service	Contact details
1			
2			

3			

Developmental history:

(e.g., delays in meeting development milestones such as speech; loss of skills that had been acquired; unusual behaviour in childhood; differences in interaction and communication; additional educational needs; etc.?)

Social interaction:

(e.g., does the person have difficulties; making and/or maintaining relationships; understanding and managing emotions; understanding other people's emotions; understanding social rules; etc.?)

Social Communication:

(e.g., difficulties in reciprocal communication; unusual speech; repetitive speech; unusual eye contact; reduced facial expression or gesturing; flat intonation; problems in understanding such as taking things literally?)

Repetitive/restricted behaviours:

(e.g., highly focused all-encompassing interests; excessive adherences to routines that are unusual; resistance to change; inflexible thinking; repetitive behaviour or rituals; strong adherence to rules; repetitive or stereotyped movements; etc.?)

Sensory differences:

(Significant differences in sensory processing? e.g., not noticing pain; noticing sounds, smells, tastes, or visual details that others do not; difficulties with food due to textures or taste sensitivities; avoiding touch; different temperature regulation; getting distressed with too much sensory stimuli; etc.)

Please provide information on the following:	
Problems in obtaining or sustaining education or employment.	
Difficulties in initiating or sustaining social relationships.	
Previous or current contact with mental health, learning disability or neurodevelopmental services.	
Information on any other diagnoses, e.g. depression, personality disorder, ADHD, etc.	
Please specify any other documentation enclosed with this referral:	
Please comment on any relevant issues relating to risk e.g. adult/child protection, criminal justice system/convictions or pending possible convictions, alcohol/drug dependency, suicidal thoughts, self-harm, etc?	
Any additional relevant information, including specific requirements when accessing the service:	
Why is a potential assessment of autism being considered at this time and whose idea was it?	

This referral will be discussed at our weekly triage meeting and you will be notified by letter of the outcome.

Consent

I understand that by consenting to this referral I am agreeing to access diagnostic assessment from the service and the organisations that work alongside it.

I understand that the information recorded will be used to help professionals understand what help I need and that it may be shared with other agencies as part of the process.

I understand that where I do not agree to sharing information with other agencies then this may affect the service provided and that I may not receive any service.

I understand the information that is recorded will be stored according to the Integrated Autism Service Information Sharing Protocol and used for the purposes of providing the support requested. I also understand that anonymised data will be shared with external partners for the purpose of monitoring and evaluation.

(If you do not consent to this information being shared please do not sign the form. If you wish to share information with particular agencies only or not share information with agencies, please specify below.)

I understand the process and consent to this information being shared ☐

I understand the process and consent to this information being shared with only the following agencies ☐

	Consent	Do not consent
Sources of Information	✓	X
GP		
Mental Health Services		
Learning Disability Services		
Social Services		
Employer		
Family		
CAMHs		
Education		
Relevant Private Sector or Third Party Organisations **(who may carry out an Assessment of Autism on our behalf)**		
Other:		

Name	
Signature	
Date	

The person lacks capacity to make the decision to consent so there needs to be a best interests decision on whether the information can be shared Signature of Decision Maker _____	Date _____

Please send this referral to:

IAS Administrator
The Integrated Autism Service
Admin floor 2
Keir Hardie Health Park
Aberdare Road
Merthyr Tydfil
CF48 1BZ

Or by email to: CTT_IAS@wales.nhs.uk

Tel: 01443 715044