INTEGRATED AUTISM SERVICE
REQUEST FOR SUPPORT

Service users details (if applicable):		
Name:	Title:	DOB:
Preferred name:		Date of referral:
Address:		NHS number (if known):
		M number (if known):
Email:		Phone:
Preferred language:	Ethnicity (e.g. Welsh, British, Indian, African) Please state:	
Gender:	Employment status:	
Referrer details (If self-referral, please leave this section blank):		
Name:		Date of referral:
Address:		Profession:
		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.			

Current Diagnosis:

Autism Spectrum Disorder ☐ Asperger Syndrome ☐

Other:

Please note, all service users requesting support **must** have a formal diagnosis of autism and provide documentation to evidence it.

Approximate year of diagnosis/age when diagnosed:

What do you want the Integrated Autism Service to help you with?

Why are you making this referral at this time? Please be as specific as possible about what you are requesting.
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.?
Additional information, including specific requirements when accessing the service:

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 support 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		
Dyscovery Centre (Who may carry out an Assessment of Autism on our behalf)		
Other - E.G. Relevant Private Sector or relevant Third Party Organisations		

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