ADHD & Autism Referral Form

NHS Hampshire and Isle of Wight

The Neurodevelopmental Single Point of Access (SPoA) accepts referrals for individuals of all ages in the Hampshire and Isle of Wight area, for the purpose of ADHD and Autism triage and onward referrals. If a individual has other neurodevelopmental or mental health needs, these must be managed separately and referred to the appropriate services.

The referral must be completed in full. If information is missing, the referral will be returned, and the individual will not be accepted to the SPOA service.

If the individual already has an open referral with an ADHD/Autism provider, please do not complete this form, as it will duplicate their referrals.

No other screening tool is required for this ADHD/Autism referral.

For referrals for Children and Young People, please ensure that the appropriate questionnaires regarding education or from parents are completed and sent along with the referral form (if appropriate).

Referrer responsibility

Responsibility for the referral, including risk management, remains with the original referrer until the referral has been reviewed and accepted by the receiving provider. Once the receiving provider has accepted the referral and added the individual to its waiting list, responsibility transfers to that provider.

Please send completed forms to: Pohl.phl-hiow-spoa@nhs.net

Individual details

Name .....

Gender ..... DOB ..... NHS Nº .....

Address .....

.....

..... Postcode .....

Phone Nº ..... Email .....

Is the individual/parent aware of the referral ☐ Yes ☐ No

Has the individual/parent consented to the referral? ☐ Yes ☐ No

Is the individual/parent aware that there are extended waiting times at present? ☐ Yes ☐ No

Is this referral a Right to Choose referral? ☐ Yes ☐ No

If so, which provider has the individual chosen to be referred to? .....

Primary contact details *for child referrals*

Contact name .....

Relationship to individual ..... Does the primary contact live with the individual? ☐ Yes ☐ No

Phone Nº ..... Email .....

GP details

Name .....

Practice .....

Phone Nº ..... Email .....

Referrer details *if different to GP*

Name .....

Organisation .....

Job title .....

Phone Nº ..... Email .....

Address .....

.....

..... Postcode .....

Date of referral .....

Before referral can proceed

Has the individual previously been referred for an ADHD assessment? Yes ☐ No ☐

Has the individual previously been referred for an Autism assessment? Yes ☐ No ☐

Is the individual currently awaiting assessment? Yes ☐ No ☐

Does the individual already hold an ADHD diagnosis? Yes ☐ No ☐

Does the individual already hold an Autism diagnosis? Yes ☐ No ☐

Details

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Reason for referral *please select* **ONE**

Please complete Sections:

NEW ADHD ADULT diagnostic assessment *Individual has not been assessed for ADHD before* ☐ A B C

NEW ADHD CHILD diagnostic assessment *Individual has not been assessed for ADHD before* ☐ A B C

NEW AUTISM ADULT diagnostic assessment *Individual has not been assessed for Autism before* ☐ A B D

NEW AUTISM CHILD diagnostic assessment *Individual has not been assessed for Autism before* ☐ A B D

MEDICATION *for initiation/titration/review or restart of medication* ☐ A B E

OTHER *please ensure full details for referral are completed in Section A* ☐ A B

Supporting information

SECTION A Why is the individual being referred?

SECTION B Risk assessment

Is there current or past risk of harm to self or others? Yes ☐ No ☐

Details

Are there any known mental health conditions? Yes ☐ No ☐

Details

Are there any safeguarding concerns? Yes ☐ No ☐

Details

Is the child a looked after child? Yes ☐ No ☐ N/A ☐

Details

SECTION B Risk assessment *continued*

Does the individual have a learning disability? Yes ☐ No ☐

Details

Does the individual have any communication needs or any reasonable adjustments needed? Yes ☐ No ☐

Details

Is there a known trauma history for the individual? Yes ☐ No ☐

Details

Is there any involvement with other agencies? Yes ☐ No ☐

Details of any health, social care or education services involved *please attach any reports which may be relevant*

Supporting information *clinical summary can be attached separately if easier*

Past medical history

SECTION B Risk assessment *continued*

Medication *including dose & frequency if applicable*

Allergies

SECTION C ADHD Referrals

Examples of inattentive symptoms causing difficulty *if applicable*

Examples of hyperactive symptoms causing difficulty *if applicable*

Examples of impulsive symptoms causing difficulty *if applicable*

At what age did the symptoms start?

Have these symptoms persisted since childhood and throughout adulthood? Yes ☐ No ☐ N/A: *Adult Onset* ☐

Which areas have been affected? *Please select as many as applicable*

Family ☐ **Work** ☐ **Education** ☐ **Life skills** ☐ **Social** ☐ **Risk** ☐

Which areas have been affected? *Continued*

Please outline below how the above area(s) of the individual's life have been affected?

SECTION D Autism Referrals

Examples of repetitive behaviour or movements causing difficulty *if applicable*

Examples of any issues with changes to routine or handling new challenges *if applicable*

Examples of any sensory issues causing difficulty *if applicable*

Examples of any issues with social interaction or communication *if applicable*

At what age did the symptoms start?

Have these symptoms persisted since childhood and throughout adulthood? Yes ☐ No ☐ N/A: *Adult Onset* ☐

Which areas have been affected? *Please select as many as applicable*

Family ☐ **Work** ☐ **Education** ☐ **Life skills** ☐ **Social** ☐ **Risk** ☐

Please outline below how the above area(s) of the individual's life have been affected?

SECTION E Medication-related referrals

Observations *within the last three months*

BP	HR	Height	Weight

Supporting documents required:

A: Copy of ADHD/Autism diagnostic report

B: Copy of all previous ADHD/Autism clinic reports

Please also enclose any other relevant reports