**Guidance for completion: *To avoid delay and/or referrals being rejected please complete all sections of the referral form – if all sections are not completed, we reserve the right to reject the referral.***

**Due to the high demand for the service, and due to commissioner changes, we are only able to accept referrals that meet the following criteria:**

* **Direct referrals from the Community Mental Health Teams for people under their care where it is identified there are co-occurring neurodevelopmental conditions and/or where the patient has support needs arising from undiagnosed neurodiverse conditions that overlap with symptoms of mental health problems; and where this creates barriers to making a diagnosis, and for the service to appropriately manage the patients' mental health.**
* **Risk of being unable to have planned life-saving hospital treatment, operations, or care placement.**
* **Risk of family court decisions determined on diagnosis e. g family breakdown, custody hearing.**

|  |  |
| --- | --- |
| **Please confirm that the person you are referring into the service meets the criteria listed** | **Yes  No** |
| **Please provide further details why the client being referred meets the above criteria including dates of potential court decisions, planned healthcare treatment:** |  |

**In addition to the above criteria:**

* **The person is 18 years old or above** at the time of the referral.
* **The person’s substances and/or alcohol** use is not at a level that may interfere with observational assessments/ability to engage in assessment process.
* **The person is deemed stable enough to undergo the assessment process**
* **The person’s BMI** is above15.
* **The person does not have Dementia or a significant Brain injury** and is not going through the diagnostic process for Dementia or needing specialist support for their Brain Injury
* **The person has given explicit consent** as indicated below.

**We accept** referrals for clients with a Learning Disability however these are only accepted if the following has been confirmed- Please note we will reject the referral without inclusion of the following information:

* **Consent has been confirmed or Mental Capacity assessment completed to prove inability to consent and then consent from Guardian.**
* **Information is provided on the person’s level of cognitive functioning, by providing cognitive/functional assessment reports.**
* **Information is provided on reasonable adjustments needed to complete assessment including access, communication needs**
* **Risk information is provided based on triggers likely to increase likelihood of behaviours that challenge (a functional analysis if possible)**

***PLEASE NOTE – TO AVOID delay and referrals being rejected please complete*** *all* ***sections of the referral form. This includes Part B of the Autism section where the person can give as much information as possible to be returned with the form.***

***If you are at all unsure about whether the individual would qualify, please contact us, using the contact details at the bottom of this page.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:**  **Referral Needed:** *(Please put x in box)* | Autism Diagnostic Assessment  ADHD Diagnostic Assessment | | |
| ***We require all referrals for ADHD to include an initial screening tool and score (Wender-Utah). Please attach the completed form.***   |  |  | | --- | --- | | ***Wender Utah ADHD scale*** | ***Score:*** | | | | |
| **Persons full name:** |  | | |
| **NHS Number:** |  | **Patient’s CCG** |  |
| **Date of Birth:** |  | | |
| **Gender:** |  | | |
| **Ethnicity:** |  | | |
| **Contact Details:** | Address: | | |
| Telephone: | | Mobile: |
| Email: | | |
| **Best way to contact individual:**  *(Please**indicate*) | Telephone  Text | | |
| Mobile  Email | | |
| Post  *After 3 attempts at contacting the client, if there is no engagement the client will be discharged from our service – please update us with any change in contact details.* | | |
| **Does the person consent to this referral?** | Yes  No | | |
| **Date consent was agreed:** |  | | |
| **Does this person have an Intellectual / Learning Disability?** | Yes/No ( if yes please provide details) | | |
| **Please specify name and contact details of other people the individual consents to being contacted (e.g., parents)** | Name:  Phone number:  Email: | | |

|  |  |
| --- | --- |
| **Person completing referral and contact details if not GP**  **Referrer Name & Contact Details:**  **Profession:** |  |
|  |
|  |
| **Registered GP contact details:** |  |
| **Other agencies involved in persons’ care:** *(Please specify contact details)*  **Please include here any Mental Health support input.** |  |
| **Have you had any other assessments that maybe relevant to the assessment process including Do-it -Profiler information?**  **Please add details here or attach as separate documents.** |  |
| **Summary of**  **Challenges (Autism):**  (The characteristics of autism are divided into three main groups (examples given). **Please give examples** for **all three areas**.  Please use the tick boxes and add additional information where necessary. | **Please only fill in this section in if you are referring for Autism assessment**  **Part A (To be completed by referrer)**  **1) Social Communication**  with verbal and non-verbal communication (e.g., eye contact modulation /difficulty. understanding facial expressions)  starting/maintaining/give-and-take of conversation, small talk, literal understanding of language, difficulty. understanding sarcasm  **Examples**  **2) Social interaction**  understanding other’s emotions/point of view  fitting in socially  initiating and maintaining relationships  preferring to spend time alone, finding people confusing/unpredictable  **Examples**  **3) a) Routines/Rituals; b) Highly focussed and intense interests; c) sensory sensitivities**  fixed daily routines  uncomfortable with change, cope better with preparation  intense interest in specific, highly focussed areas of interest  hyper-/hyposensitive to one or more senses  **Examples**  **4) Have the above difficulties been present in childhood?**  (Note as autism is developmental it is important that challenges are longstanding)  **Part B (To be completed by person being referred)**  **Please could you provide examples of why you believe you may be autistic?**  (If you struggle to answer please ask people who know you well to support you to fill in the form)  **Examples may include the reasons why you feel different to others. This maybe in the areas of social communication and interaction, difficulty with coping with changes and how you experience the world.** |
| **Summary of**  **Challenges (ADHD):**  Please give examples for **all areas**. | **Please only fill in section in if you are referring for ADHD assessment.**  **If you are referring for an ADHD Medication Review or Annual Medication Review, you will need to complete a separate referral form.**   1. **Poor Attention and concentration (Occasional hyperfocus is common)** 2. **Impulsive behaviours** 3. **Poor Organisation skills** 4. **Restlessness, difficulty. keeping quiet and interrupting others, irritability/quick temper** 5. **Have the above difficulties been present in childhood?**   **(Note as ADHD is a developmental condition it is important that challenges are longstanding)** |
| **Current/co-existing mental health or history of mental health issues** | *Please state here any Mental Health diagnosis known*  *Any relevant mental health reports are required – please attach with referral* |
| **Current or historic risks to self or others** | *Please include any details* |
| **At time of referral is this person currently stable enough to cope with the assessment process.**  **Yes  No  Don’t know** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Medication:** *(Please attach a copy of the health record)* | |  | |
| **Any physical health problems:** *(Please attach any relevant reports)* | | **Yes / No** | |
| **Any reasonable adjustments needed?** | ***Yes / No***  *E.g., accessible entrance, communication needs.* | | |
| **Is an interpreter required for the person?** | *Please provide full details* | | |
| **Name and contact no. of next of kin or person to contact in an emergency:** | *Name:* | | *Contact No.*  *Relationship to person:* |

|  |
| --- |
| **Data Protection:** |
| By submitting this form, you agree that you have obtained the consent of the person who the information is about.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  For the purposes of this form The Retreat York is the data controller for the collection, processing, sharing and storage of this data. All information collected in this form will be treated confidentially and will be used for the sole purpose of providing a clinical service to the person above. Their information may be passed onto third parties who help support us in the provision and administration of our services or where we have their consent to do this. Please note, this confidentiality is not absolute and may be broken where we have a legal obligation to comply with the law for e.g., the information is required to identify potential fraud or to detect a crime or to apprehend an offender or where there is a rising safety or safeguarding issue. Further information about this can be found in our Privacy Notice on our website at: <https://www.theretreatclinics.org.uk/>**.** Alternatively, you can contact our Data Protection Officer for further information at: The Retreat York, 107 Heslington Road, York, Y010 5BN or email us at: [DPO@TheRetreatYork.org.uk](mailto:DPO@TheRetreatYork.org.uk). |