Referral Guidance Please Read In Full Before Completion (Age 6 and over only)

- Please note in order for the Alderhey Autism Spectrum Disorder service to be able to start the assessment process, the referral form needs to be completed in its entirety and sent to us.
- You can submit this form either electronically by saving it into a PDF format and email it over to our Booking & Scheduling team refertoalderhey@nhs.net .
- Or by post to the following address: Referrals, Alder Hey Children's NHS Foundation Trust, Eaton Road, L12 2AP.
- Please note we accepts referrals from GP's, School, Health & Social Care or any other named or appropriate professional working with the Child or Young Person.
- All referrals will need to be generated in partnership with the Child or Young Person's parent or carer.
- For the best outcome for the Child or Young Person, the form should be completed by a person who knows the child well and sees them on a regular basis; in school if this is practicable
- Please note if the evidence is not received in totality or does not meet the criteria we will be unable to progress with the referral and the referral will be rejected.
- For further guidance on completing this form, please email asdqueries@alderhey.nhs.uk
- Upon review of the referral form, we will either accept referral or contact the referrer to outline reasons the referral was not accepted and suggest alternative route/service.
- Referrer, parent/guardian, GP and school nurse team will be copied into all correspondence.
- Please note there is a separate referral form for ADHD available on the Alder Hey website.
- Please note Alder Hey ASD diagnostic services will not accept any referrals for ASD under the age of 6 years old. Concerns in relation to children under 6 years old should be directed to Developmental Paediatrics using their referral from whch can be found at https://alderhey.nhs.uk/services/developmental-paediatrics .
- To improve patient outcomes we require referral age of 16 years plus to consent for ASD team to progress with the assessment where clinically appropriate.
- If your referral is to request assessment for Pathological Demand Avoidance profile assessment / diagnosis, please complete this form in full indicating your request. (Only Children and young people with an existing diagnosis of Autism Spectrum disorder over the age of 6 years old can be assessed for Pathological Demand Avoidance Profile.)

Alder Hey Children's NHS Foundation Trust

Developmental Paediatric Department Referral

Date:					
Patient Details	NHS No/ AH number if known				
Name					
DOB		Age		Gender	
Address					
Postcode		Home Telephone: Mobile Telephone:			
Language (if not English)		Translator Needed			
Parent/Carer Email Address					
Does the Parent/Carer have readily available internet access in a private setting? N.B. Parts of our assessment service will endeavour to use virtual appointments, however we can accommodate alternative arrangements if these are not possible			Yes ☐	No ☐	
Do any of these apply:	Looked After Child ☐	Child Protection Plan ☐	Child in Need ☐		
School/Nursery					

Other agencies involved	EHAT/Early Help ☐	CAMHS ☐	Speech and Language ☐
	Physiotherapy ☐	Occupational Therapy ☐	Social Services ☐
	Other ☐	(if other please specify)	

GP Name		Practice Name	
Address			
Postcode		Telephone	

Referrer Details **if not** GP

Name		Role	
Address			
Postcode		Telephone	

Alder Hey Children's NHS Foundation Trust

Alder Hey Autism Spectrum Pathway Referral

Please provide as much information as you can and attach any relevant reports that will support the referral. Should you have any queries regarding this form, please contact the team on **0151 252 5252 or 0151 252 5759.** This information can be completed by any professional who knows the child well, but we will not be able to proceed with the referral unless this information is completed.

Child's Name: **DOB**:

Neurodevelopmental Concerns
Brief history of development (age when concerns began / prematurity/ age achieved milestones / speech development / play skills / physical health issues? etc.)
Social Interaction and Communication Concerns
(awareness of others / interest in people / seeking comfort /empathy skills /awareness of feelings and emotions / giving comfort / building friendship / turn taking / eye contact / gesture / inappropriate behaviour /use of language for range of functions / topic selection / selection and maintenance of conversation /awareness of listener / vocabulary development / voice control, tone, volume, rate, expression / response to interaction / understanding of complex and non-literal language /understanding of gesture, tone and facial expression.

Behaviour Concerns
Behaviour (pretend play / imagination / need for routine / resistance to change /repetitive or stereotyped behaviour / obsessions or movements / all consuming interests)
Sensory differences (smell, clothing, noises, lights etc.)
Significant Life Events

Family circumstances (bereavements, parental mental health / domestic violence / social care involvement / LAC status etc.)
Learning / Academic Performance
Learning / development (Cognitive difficulties, school performance, attendance, current support etc)
Language
(Level of understanding, speech clarity, expressive language skills, selective mutism, fluency (stammering)).

Has an Early Help Assessment Tool (EHAT) or similar been opened? YES ☐ NO ☐
(If YES please attached copies of EHAT and reviews. To check if an EHAT is in place please contact 0151 233 5772. If NO please provide evidence of support/interventions offered)

Has a Team around the Family meeting been organised? YES ☐ NO ☐
(If yes please attached copies of TAFs meetings or date of first meeting)

Information and support provided by school (Graduated Approach) YES ☐ NO ☐
(If yes please attached information of last two review meetings)

Are you aware of any previous or current safeguarding concerns?
If YES please provide more information below:

Do you require an assessment for Pathological demand avoidance profile? YES ☐ NO ☐
(please note this condition can only be added if your child has an existing diagnosis of ASD)

What is the Child's/Young Person's preferred form of communication?	Spoken Language	YES ☐ NO ☐ N/A ☐
	Written Language	YES ☐ NO ☐ N/A ☐
	Signing (what type? e.g. Makaton) ……	YES ☐ NO ☐ N/A ☐
	Symbols	YES ☐ NO ☐ N/A ☐
	PECS	YES ☐ NO ☐ N/A ☐
	Photos/pictures	YES ☐ NO ☐ N/A ☐
	Other:	
Do Parent/Carers have any specific requirements/needs that we need to be aware of? *If YES, please describe them below*.		YES ☐ NO ☐ N/A ☐
Does the Child/Young Person have any specific requirements/needs that should be taken into consideration (e.g. sensory needs, behavioural difficulties). *If YES, please describe them below*.		YES ☐ NO ☐ N/A ☐

Additional information	
Have the family been involved with or signposted to **ADDvanced Solution Community or any other support network**?	YES ☐ NO ☐ N/A ☐
Details of support accessed:	
Have the family been involved with or signposted to **the Liverpool ASD Training Team in Liverpool for pre-referral support?**	YES ☐ NO ☐
Details of support accessed:	
Have the family been involved with or signposted to **the Isabella Trust**?	YES ☐ NO ☐
Details of support accessed:	
Has the Child / Young Person been referred to/known to **the Speech and Language Therapy Service**?	YES ☐ NO ☐
Details of support accessed:	
Has the Child / Young Person been referred to/known to **the Occupational Therapy or Physiotherapy Service**?	YES ☐ NO ☐
Details of support accessed:	
Has the Child / Young Person/ Family been referred to/known to **Mental Health or Psychotherapy Service**? (e.g. CAMHS, YPAS)	YES ☐ NO ☐
Details of support accessed:	
Has **<u>any other support</u> been** offered to the Child/Young Person/Family in relation to behaviour(s) causing concern from other services?	YES ☐ NO ☐
Details of support accessed:	

Alder Hey Children's NHS Foundation Trust

Alder Hey Autism Spectrum Pathway

Parent/Carer Consent Form

I/We (print parent's name) …….....

Parent/carer of (print child's name) …….....

I understand that my/our child has been referred to the Alder Hey Autism Spectrum Pathway and this referral has been fully explained to me/us. I/We understand that following the assessment outcome, my child / young person may be given a diagnosis of autism spectrum disorder / pathological demand avoidance profile. I agree that I fully understand this and consent for the assessment to take place.

I/We give permission for the Alder Hey Autism Spectrum Pathway to undertake assessments as appropriate. Permission is also given to gather, discuss & share applicable information in respect to my/our child's Autism Spectrum Disorder assessment within the team & appropriate outside agencies. Where applicable, this may include:

School and SENCO; including School observations	Speech and Language Therapy Service
Clinical Psychology	Health Visitor
Paediatrician	Social Worker, Social Services
Educational Psychology Service	Child and Adolescent Mental Health Services
GP	Learning Disability Team
Alder Hey/Hospital Contact	ASD Training Team
Occupational Therapy Service	Other e.g. Children's Centre, Children's Services

I/We understand that only one parent who has parental responsibility is required for an assessment to be completed.

Once all assessments are completed I/ We will be invited to opt in for a feedback session. **I/We understand attending the feedback session is strongly advised as the outcome of the assessment will be discussed.** I/We agree it is in the child's best interest that the feedback session is attended.

If I/We do not attend the feedback session as advised or make any contact with the ASD Team to discuss this matter **a copy of the report containing the outcome of the assessment will be sent to my/our address & GP.**

I/We understand that demographic data in relation to my child will be shared with Addvanced solutions so they are able to communicate we us in regard to training / events that are taking place.

I/We understand that information concerning risk of harm to a child or young person must always be shared for safeguarding reasons.

This form has been fully explained to me.

I can confirm I have read the above and give my consent as legal guardian.

Name of person with parental responsibility: _____

Signed: _____ Date: _____

If the Young person is aged 16 and over, they must give consent for the ASD team to progress with the assessment

Young Person_____

Any other comments the young person would like to add:

Young Person Signature: _____ Date: _____

Before sending the referral to the Alder Hey ASD Pathway please ensure that you are submitting the correct information as listed below:

Check list

- The ASD section has been completed YES ☐ NO ☐
- The Child has Liverpool or Sefton GP YES ☐ NO ☐
- Copies of any EHAT, TAF meetings, SEND Graduated Approach or any evidence of support /interventions offered and family engagement have been attached YES ☐ NO ☐
- The referral includes information from school YES ☐ NO ☐
- The Additional Information section has been completed YES ☐ NO ☐
- The consent form has been signed and attached to this referral YES ☐ NO ☐

Please be aware that the Alder Hey ASD Pathway is not able to accept incomplete referral forms. If insufficient information is submitted or there is lack of evidence of engagement with local support services, the referral will be rejected and returned back to the referrer.

We will try to accommodate any additional needs for the child or the parents/ carers where possible.

Please be aware that the ASD Pathway is a diagnostic service and hence evidence of support needs to be provided prior to the acceptance of the referral to support the process.

Alder Hey Children's NHS Foundation Trust

Support Agencies

Please note that there is more information around support on our website.
https://www.alderhey.nhs.uk

Liverpool Specific	Sefton Specific
SENDIASS Tel. 0800 0129066 **Liverpool ASD Training Team** **asdtrainingteam@liverpool.gov.uk** Tel. 0151 233 5988 **The Isabella Trust** Tel. 07956 749 774 **LivPaC (Parent Carer Forum)** Tel. 0151 7275271, 07504 544638 **SEND local offer** https://fsd.liverpool.gov.uk/kb5/liverpool/fsd/localoffer.page	**SENDIASS** Tel. 0151 934 3334 **Autism and Social Communication Team** Tel. 0151 934 2347 **The Isabella Trust** Tel. 07956 749 774 **Sefton Parent Carer Forum** Tel. 07541 326860 **Email:** info@seftonpcf.org **SEND local offer** https://www.seftondirectory.com/kb5/sefton/directory/localoffer.page?localofferchannel=0

CAMHS - Tel. 0151 293 3662 (Mon-Fri 9am – 5pm)

YPAS - Tel. 0151 707 1025

ADDvanced Solutions Community Network - Tel. 0151 486 1788

CAMHS Crisis Line - Tel. 0151 293 3577 (Mon-Fri 8am to 8pm and on weekends/Bank Holidays from 10am – 4pm)