**Referral to the Adult Neurodevelopmental service for Autism/ADHD Diagnosis or ADHD Medication review**

We would encourage you to fill out the web referral form where possible:

<https://www.kentcht.nhs.uk/service/asd-adhd/>

Sections within this form marked **\*** are mandatory for completion

1. **Patient details\***

|  |  |
| --- | --- |
| Name: | Date of birth: |
| Full address: | NHS number: |
| Contact email: | Phone number: |
| Gender: | Ethnicity: |

1. **Referrer details\***

|  |  |
| --- | --- |
| Name: | Referral source: (Role/relationship/position) |
| Address: | Email: |
| Phone: |

1. **GP details\***

|  |  |
| --- | --- |
| Surgery name: | GP name (if known): |
| Surgery address: | Email: |
| Phone: |

**4. Referral type\***

Please tick which of the following you are referring for and note the screening tools that must be completed and submitted with this referral form:

**ASD Diagnostic Assessment –*****completed AQ50***

**ADHD Diagnostic Assessment** - ***completed ASRS v1.1***

**ADHD Medication review (existing diagnosis)** - ***ASRS v1.1, Evidence of diagnosis (for example, diagnostic report, clinic letters) GP medical summary, cardiac questionnaire.***

\* **If evidence cannot be produced, the individual would need to be referred into the service for a diagnostic assessment.**

|  |
| --- |
| 1. **Please tick if the patient has any of the following:**   **Suspected / Diagnosed Personality Disorder  Previous ASD diagnosis**  **Current Symptoms of Psychosis  Previous ADHD diagnosis**  **Learning Disability** |
| **If you ticked that the patient has a Suspected/Diagnosed Personality Disorder, please provide further details here**  (for example, type of diagnosis, when and where they were diagnosed, any supporting documentation) |
|  |
| 1. **Is the patient Alcohol and/or drug dependant?** |
|  |
| 1. **Is the patient currently being seen by a local mental health team, for example, CMHT, NHS Talking Therapies LD?** |
|  |
| 1. **Risk and safeguarding concerns:\*** |
| Suicide  Self-harm  Self-neglect  Risk from others  Posing risk to others  Child Protection  No risks or safeguarding issues  Current criminal justice proceedings  Forensic history |
| **Please confirm:\*** |
| Any risks identified above are being managed outside of this referral and appropriate onward referrals have been made |

|  |
| --- |
| Please provide details of any current safeguarding concerns, for example, family court /child protection, individual vulnerability abuse/neglect  Please provide detail of any current or historical forensic or criminal justice proceedings |

1. **ASD / ADHD diagnostic assessments:**

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| --- |
| 1. **What has led to the patient seeking a referral for ASD/ADHD diagnostic assessment now?** |
|  |
| 1. **What difficulties are being caused by apparent ASD/ADHD symptoms/behaviours**   (for example, problems in relationships, concentration at work)? |
|  |
| 1. **In what way does the patient hope to benefit from an assessment for autism/ADHD?** |
|  |

1. **ASD diagnostic assessment:**

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| --- | --- |
| **Please place a tick next to the option that best describes the patient:** | |
| **Eye contact** | Good  Fair  Poor |
| **Engagement in conversation** | Easy back and forth conversational flow  Conversation follows own interests with little listener awareness  Patient responds minimally to questions/does not offer information |
| **Tone of voice** | Appropriate variation in pitch and tone  Speech is somewhat monotone  Unusually loud or quiet at times |
| **Is the patient dependent on family or friends for everyday tasks?**  For example, finance management, shopping etc | Yes  No |
| **Does the patient report having any sensory sensitivities?** | None  Smell  Taste  Light  Textures  Sounds |
| **In addition to yourself, has any other professional ever suggested the patient might have ASD?** | Yes  No |

1. **ADHD medication review:**

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| --- |
| 1. **When was the patient diagnosed with ADHD?** |
|  |
| 1. **Is the patient currently taking ADHD medication?** |
|  |
| 1. **When was the patient last reviewed for ADHD and by whom?** |
|  |
| 1. **Are you the prescribing GP under a Kent and Medway (LES) shared care arrangement? *(please state reason for core service to undertake a review)*** |
|  |

1. **ADHD review or assessment:**

|  |  |
| --- | --- |
| **Please provide baseline measures:** | |
| **Blood pressure:** |  |
| **Pulse:** |  |
| **Height:** |  |
| **Weight:** |  |

1. **Reasonable adjustments**

|  |  |
| --- | --- |
| **Support to complete additional written self-assessment documents** | Yes  No |
| **British sign language interpreter** | Yes  No |
| **Step free access/ground floor consulting room** | Yes  No |
| **Language translation** | Yes  No |
| **Longer appointment** | Yes  No |
| **Further information:** | |

1. **Supporting information**

Please attach relevant clinical correspondence and reports – important information includes:

* **current/past CMHT reports**
* **previous ADHD Assessment letters**
* **copies of previous involvement with the Child and Adolescent Service**

**Please confirm the documents you have attached:**

**ASRS**

**AQ50**

**Diagnostic report**

**GP Med Summary**

**Cardiac questionnaire**

**Other supporting documents**

|  |  |
| --- | --- |
| **Date of referral:** |  |

**If a referral is incomplete this will be returned. The clinical team require sufficient information to enable them to complete the triage process.**

Please send this completed referral form and associated documents via email to – [kentchft.AdultsNDReferral@nhs.net](mailto:kentchft.AdultsNDReferral@nhs.net)

If you would like to find out what happens to personal information held about you, please read the [your personal information](https://www.kentcht.nhs.uk/legal/#YourPersonalInformation) section on our Legal page. You can also read our [privacy policy](https://www.kentcht.nhs.uk/legal/) for more information.