**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?**
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|  |
| 1. **Is the patient currently being seen by a local mental health team, for example, CMHT, NHS Talking Therapies LD?**
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|  |
| 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?**
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|  |
| 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?**
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|  |

1. **ASD diagnostic assessment:**

|  |
| --- |
| **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?**
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|  |
| 1. **Is the patient currently taking ADHD medication?**
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|  |
| 1. **When was the patient last reviewed for ADHD and by whom?**
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|  |
| 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)***
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|  |

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

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.