Tower Hamlets Autism Service Referral Form

The Tower Hamlets Autism Service (THAS) offers assessment, diagnosis and initial support to those who may be on the Autistic Spectrum.

To be considered for this service, referrals must meet the following criteria (please tick)

* Over 18 years
* Living in Tower Hamlets
* No diagnosis of Learning Disability
* No existing diagnosis of autism OR previous assessment for autism

Please fill out this form completely and provide as much detail as possible

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| --- | --- | --- | --- |
| Forenames: |  | Surname: |  |
| Date of Birth: |  | NHS/ Rio No.:  |  |
| Gender: |  | Pronouns: |  |
| Address: |  | Phone No.: |  |
| Email address: |  |

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| --- | --- | --- | --- |
| GP Name: |  | Phone No.: |  |
| GP Practice address: |  |
| Referrer Name:  |  | Phone No.: |  |
| Referrer address: |  |
| Referral Date: |  |  [ ]  New Referral [ ]  Re-Referral [ ]  Unsure |
| Has the person consented to the referral? [ ]  Yes [ ]  NoPlease note, referrals will not be accepted without informed consent.  |
| Ethnicity: | (monitoring purposes) | Preferred Language: |  | Is an interpreter required? [ ]  Yes [ ]  No |
| Next of Kin/ Carer |  | Phone Number: |  |
| Address: |  |

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| Does the person report any current or childhood social interaction difficulties? If yes, please provide examples.(e.g.: making and/or maintaining relationships; understanding and managing emotions; understanding other people’s emotions; understanding social rules etc.) |
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| Does the person report any current or childhood social communication difficulties? If yes, please provide examples.(e.g.: in reciprocal communication; repetitive speech; eye contact; facial expression or gesturing; understanding things literally etc.) |
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| Does the person report any current or childhood restrictive, repetitive patterns of behaviours or interests? If yes, please provide examples.(e.g.: highly focused all-encompassing interests; excessive adherences to routines; resistance to change; inflexible thinking; repetitive or stereotyped movements etc.) |
|  |
| Does the person report any current or childhood sensory processing differences? If yes, please provide examples.(e.g.: not noticing pain; noticing sounds, smells, tastes, or visual details that others do not; difficulties with textures or taste sensitivities etc.) |
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| Beyond diagnosis, what kind of help/ support might the person want from the Tower Hamlets Autism Service?  |
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| Special considerations and reasonable adjustments (e.g.: difficulties attending appointments, or other special adjustments) |
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| Risk assessmentPlease tick any that apply and provide further details | [ ]  Risk to self/ suicidal thoughts[ ]  Self neglect[ ]  Risk to others[ ]  Risk from others[ ]  Other[ ]  None known | Further details: |
| **Please fill out the this referral form and all questionnaires included and provide any background information that you feel would be helpful such as previous assessments or CPA documents, to the address above.****By making this referral, you are giving your consent for us to access your health and social care records as necessary to inform the screening and assessment process.** **If you do not want us to access your records please contact us to discuss this, however be aware it may affect the care we are able to offer you.****If we are concerned about a potential risk to you or others, we may need to share information with other relevant teams without initially getting consent from you to do so.****Please be advised we do not support with Housing or Benefits.****Housing Inquiries: 020 7364 7474****Benefits support: 020 7247 1050****Crisis Team: 0800 073 0003****Samaritans: 020 7734 2800** |