Neurodevelopmental Referral Form

(Attention Deficit Hyperactivity Disorder (ADHD)
& Autism Spectrum Condition)

REFERRAL FOR ASSESSMENT

This referral form replaces all previous referral forms for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Condition (ASC) assessment requests. It is applicable to all of MPFT Children's Services and is the start of work towards an integrated Neurodevelopmental Pathway. We have streamlined the form and integrated all the information that we require to be able to triage assessment requests – **there will no longer be a school report form in addition to this information**.

This is a referral form for a specialist assessment. Before this can be carried out it is important that a child/ young person's needs are assessed and supported as the first step in understanding their presenting difficulties.

- The graduated response toolkit is a resource for schools and colleges to help make sure children and young people with Special Educational Needs reach their full potential, evidence will be required to demonstrate how a graduated response has been followed to support the child/ young person's needs within their educational setting prior to referral. Further information can be found at Graduated response toolkit - Staffordshire County Council
- Further information around taking a needs led approach can be found in the leaflet 'ADHD Assessment Requests' on our website Professionals :: Midlands Partnership University NHS Foundation Trust (mpft.nhs.uk)
- Further information regarding Autism assessments can be found via the CYP Autism Service website Children and Young People's Autism Service :: Midlands Partnership University NHS Foundation Trust (mpft.nhs.uk).

To ensure that our services are in the best position to understand a child or young person's needs **all sections of this referral form MUST be completed**. Additional reports can be provided when indicated as supporting evidence.

Referrals are accepted from professionals only. We advise that the professional that knows the child the best makes the referral together with their parent/carer. Usually this Professional would be from a child/young person's educational setting. If education are not making the referral, detailed information from education is required.

Please note that there is no change to how referrals are made to CAMHS and Community Paediatrics. Mental health referrals continue to be made on the CAMHS referral form, and concerns about development are to be made on the Community Paediatrics referral form.

PRE-REFERRAL CHECKLIST

Please conform the following before you proceed to make an assessment request

☐ I have gathered parent/carer feedback
☐ A graduated response within education has been followed to support the CYP needs prior to this request
☐ I am referring from education or have had feedback from education to complete this referral

Referrals received without this information will be returned to you for completion before the referral is screened by the clinical team.

PART ONE: DEMOGRAPHIC INFORMATION

CHILD/ YOUNG PERSON DETAILS	
Full Name:	Date of Birth:
Preferred Name:	NHS Number:
Preferred Pronouns:	Ethnicity:
Gender:	Is Gender same as assigned at birth? Yes / ☐ No ☐
Address:	
CYP Phone Number: Parent/ Carer Phone Number:	1st Language (if not English): Interpreter required?
GP (General Practitioner) Surgery / Address:	

PARENT/CARER DETAILS	
Parent/ Carer 1	**Parent/Carer 2**
Full Name:	Full Name:
Address:	Address:
Relationship to CYP:	Relationship to CYP:
Holds parental responsibility?	Holds parental responsibility?
Phone number:	Phone number:
Email address:	Email address:
Does parent /carer consent to receiving correspondence electronically via email Yes / ☐ No ☐	Does parent /carer consent to receiving correspondence electronically via email Yes / ☐ No ☐
1st Language (if not English):	1st Language (if not English):
Reasonable adjustments to support parent/carer: Visual Impairment Yes / ☐ No ☐ Hearing impairment Yes / ☐ No ☐ Physical access Yes / ☐ No ☐ Learning Disability Yes / ☐ No ☐ Interpreter Yes / ☐ No ☐ *Please provide details:*	Reasonable adjustments to support parent/carer: Visual Impairment Yes / ☐ No ☐ Hearing impairment Yes / ☐ No ☐ Physical access Yes / ☐ No ☐ Learning Disability Yes / ☐ No ☐ Interpreter Yes / ☐ No ☐ *Please provide details:*
If parent/carer(s) above do not hold parental responsibility, provide details of person/authority who does:	
Full Name:	Relationship to CYP:
Address:	
Phone Number:	Email:

CONSENT
Please confirm who is aware of this referral for assessment and consent given? ☐ Child/ Young Person (Where the CYP has competency to do so, they have informed consent for the assessment) ☐ Parent/ Carer Name ☐ Person/ Authority with parental responsibility (*as above*) Name

If the referral does not meet criteria, is the parent/carer happy for us to pass it onto any other relevant agency?

☐ Yes ☐ No

LEGAL STATUS

Tick any of the following that apply to the child/ young person and complete details:	Social worker:
☐ Looked After Child *	Name:
☐ Subject to a Child Protection Plan *	Contact Number:
☐ Subject to a Child in Need Plan *	Email:
☐ Adopted *	
☐ Under Special Guardianship	
☐ Currently or previously under Mental Health Act	
* If yes to any of the above and where there is an allocated Social Worker, please provide their details and ensure they are aware of this referral.	

REASON FOR REFERRAL

☐ Assessment for Autism Spectrum Condition (ASC)

For referrals for Autism in Children under 5 years please complete the Community Paediatric referral form, so that the child's development can be assessed in the first instance.

☐ Assessment for Attention Deficit Hyperactivity Disorder (ADHD)

Please expand on your reasons for making the referral at this time

What is the child/ young person's view of their difficulties and what do they feel they need support with?

PART 2: PRESENTING NEEDS

This section gives you space to tell us about the child/young person's presenting needs along with the relevant background history. Please ensure that you have parent/carer perspective along with the required school information.

DEVELOPMENTAL HISTORY

Pregnancy / birth / prematurity / complications / temperament as a baby? Regression or loss of skills? What age were milestone met (walking / talking / toileting)

FAMILY / SOCIAL HISTORY

Family circumstances. Who Lives at home with the CYP? Known Autism/ ADHD/ Learning Difficulties in the wider family? Significant life events for the child - Bereavements / house moves / school moves / parental relationships/ domestic violence/ trauma.

SPEECH LANGUAGE AND COMMUNICATION

Speech milestones – babbling / first words / sentences / loss of speech or regression. Level of understanding / speech clarity / expressive language skills / selective mutism / fluency / stammering / volume control / understanding of literal language / sarcasm / avoid conversation / initiating conversation / processing speed. Preferred method of communication? Use of alternative communication tools?

SOCIAL, EMOTIONAL AND MENTAL HEALTH

Awareness of others / interest in people / seeking comfort / empathy for others / awareness of own feelings and emotions / building and maintaining friendships / turn taking / eye contact / gestures and use of body language. Do you feel social interaction is age appropriate?

PLAY & BEHAVIOUR

Do you feel play is age appropriate for this child? Special interests & topics / Sleep hygiene / awareness of dangers / rules of hierarchy / response to change / specific routines / self-stimulating behaviours / rigidity of thoughts & behaviours / accepting other opinions / risk taking behaviours

SENSORY AND/OR PHYSICAL NEEDS

Sensory seeking, sensory avoidance, sensory sensitivity with touch, sound, visual, movement, taste, smell. Adaptations made to support CYP (Children and Young People) / personal cares / eating and drinking / clothing / fine motor skills / gross motor movements / co-ordination / hypermobility / pain response / gait / tip toe walking / self – regulating behaviours observed.

MEDICAL CONDITIONS

Does the CYP have any diagnosed medical conditions? Yes / ☐ No ☐ If Yes please provide details:

EDUCATION

Current Place of Education	Contact details same as Referrer? Yes No ☐ ☐
Name: Address: Previous Schools:	If No, please provide Contact details of SENCO: Name: Telephone: Email:

COGNITION AND LEARNING

Please complete the following:

	Working below	Working towards	Working at	Working above
Age related expectations				
General level of attainment				
Reading				
Writing				
Maths				
Spelling				

☐ CYP supported through Assess, Plan, Do, Review (APDR) / Enhanced APDR *
☐ CYP supported through SEN Plan or equivalent for setting *
☐ CYP supported through an Education & Health Care Plan (EHCP)*
☐ CYP has a diagnosed learning disability

GRADUATED RESPONSE

Please tell us how a graduated response has been followed to understand and support this child/young person's needs, and their response to this.

SCHOOL OBSERVATIONS

Compared to their peers how would you rate the child/ young person in terms of the level of the following?

	Major Problem	Medium Problem	Minor Problem	No Problem	Provide Context of behaviour and examples
Interrupting in other's conversations					
Speaking out of turn					
Excessive and inappropriate talking					
Difficulty turn taking					
Forgetfulness					
Memory					
Losing things necessary for certain tasks e.g. books					
Poor organisation					
Level of understanding					
Difficulties listening to instructions					
Leaving seat without permission					
Fidgeting or squirming					
Excessive or inappropriate running					
Excessive motor activity					
Excessively noisy in play					
Careless errors in work					
Easily distracted					
Difficulties sustaining attention					
Dislike of tasks requiring concentration					
Response to rules and discipline					
Low self esteem					
Awareness of dangers					

IMPACT AT SCHOOL

How are these difficulties impacting within education setting and current strategies used to support?

IMPACT ON THE CHILD / YOUNG PERSON

Please detail the impact of the above presentation on the child/young person, their daily functioning, and future outcomes. Does their presentation differ between home/school settings?

PART 3: PREVIOUS & CURRENT SERVICES INVOLVEMENT

Which services have had previous involvement with this child and family?

- ☐ 0-19 Universal Service (health visitor/ school nursing)
- ☐ Audiology
- ☐ Speech and Language Therapy
- ☐ Dietitian
- ☐ Paediatric Occupational Therapy
- ☐ Family support
- ☐ Early Help Service
- ☐ Learning and/or behaviour support services in school
- ☐ Educational Psychology
- ☐ CAMHS
- ☐ CYP Autism Service
- ☐ Paediatrics (acute or community)
- ☐ Youth Offending Service
- ☐ Other, please provide details:

Please tell us which services are currently involved in the space below:

SUPPORTING INFORMATION

Reports attached / included with referral? Yes / ☐ No ☐ If Yes please provide details:

PART 4: RISK INFORMATION

Is the CYP currently on the Dynamic Support Register (DSR)? Yes / ☐ No ☐

Is there risk to self?

Self-injurious behaviour	Yes / ☐ No ☐
Self-harm	Yes / ☐ No ☐
Suicidal ideation	Yes / ☐ No ☐
Suicidal intent	Yes / ☐ No ☐
Self-neglect	Yes / ☐ No ☐
Substance Misuse	Yes / ☐ No ☐

<u>If yes to any of the above</u>; *Please expand with details for us to understand the context of risk. Please attach Safety Plan and what advice you have you given:*

Is there a risk to others?

Physical Aggression / Violence	Yes / ☐ No ☐
Verbal aggression / Violence	Yes / ☐ No ☐
Ideas of harming other people	Yes / ☐ No ☐
Ideas of harming animals	Yes / ☐ No ☐
Sexualised behaviours	Yes / ☐ No ☐

<u>If yes to any of the above</u>; *Please expand with details for us to understand the context of risk. Please attach Safety Plan and what advice you have you given:*

Is there a risk posed by others?

Vulnerability Current / Historical	Yes / ☐ No ☐
Exploitation	Yes / ☐ No ☐
Cultural Factors	Yes / ☐ No ☐
Environmental Factors	Yes / ☐ No ☐
Awareness of Dangers	Yes / ☐ No ☐

<u>If yes to any of the above</u>; *Please expand with details for us to understand the context of risk. Please attach Safety Plan and what advice you have you given:*

REFERRER DETAILS
Name:

Job Title:	Agency:
Address:	
Email Address:	Contact Number:
DATE OF REFERRAL:	

This form should be returned via email to:

ADHD Requests (Age 6-11) Community Paediatrics	ADHD Requests (Over Age 11) CaFSPA	Autism Assessments CYP Autism Service
CommunityPaedsreferrals@mpft.nhs.uk https://www.mpft.nhs.uk/services/community-paediatrics 01283 505160	cafspa@mpft.nhs.uk https://camhs.mpft.nhs.uk/ 08081780611 – Option 2	autism.referrals@mpft.nhs.uk https://www.mpft.nhs.uk/services/children-and-young-people-autism-service 0300 303 0691