

Specialist Assessment Service
(Previously known as Meadow Centre Service)

REFERRAL FORM

The Specialist Assessment Service works with children who have either complex medical and developmental needs or with children and young people where their difficulties may indicate an Autism Spectrum Disorder (ASD). For children with complex medical needs we may also provide coordinated therapeutic work to meet a child's needs.

Service referral criteria are in place to ensure that this service works with the child/young people and their families who need and will benefit from further highly specialist assessment.

We require a wide range of detailed information to decide if this is the most appropriate service for a child or young person. The information provided forms part of the child/young person's assessment if they are accepted.

Before you complete this form please check:-

1. The referral has been discussed and agreed with parents/carers.
2. The child/young person is aged between 0 years and 17 years 11 months for an Autism assessment or is under 5 years old for a complex medical needs assessment.
3. The child/young person is registered with a Solihull GP.

For child/young person with difficulties that may indicate an ASD you will also need to:

1. Provide evidence of significant difficulties, impacting on their daily lives, across the 3 areas of their development associated with ASD: Social interaction, communication and flexibility of thought and behaviour.
2. Provide evidence that a graduated response, to meet a child's individual needs, has been put in place for a minimum of 6 months or 2 terms for all school aged children. This graduated response could be from e.g. Specialist Educational Services, Health Visitors, Paediatrician, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Solar (CAMHS) etc. The evidence needs to tell us the outcomes of the support put in place and this form will guide you as to how to provide this level of detail.
3. For this group of children we need parents/carers and professionals to work in partnership to complete this form so that we understand how the child/young person presents at home and at school. In a school setting the form should be completed and signed by the school ASD Lead or SENCo. If no problems are being seen in school we will still need the school view.

For children referred with a complex medical and/or developmental need please also provide:

1. Information to support the referral that details significant medical needs or difficulties which impact across all areas of a child's development e.g. gross & fine motor, communication, sensory concerns, learning & play.
2. Information to inform us that the child requires a highly specialist assessment and would benefit from specialist coordinated care packages to ensure their needs are best met.
 - This referral form is **NOT** to be used for a Dysphagia (Swallowing Difficulty) referral. The Specialist Assessment Service cannot accept responsibility for Dysphagia referrals on this paperwork. A separate Dysphagia Referral form exists which you will need to request from Community Therapies

1. Why are you referring this child/young person <i>Please tick appropriate box</i>	
Specialist assessment of complex medical and/or developmental needs (complete sections 1- 15 and 25 & 26)	
Specialist assessment of social communication difficulties including the possibility of an Autism Spectrum Disorder (ASD). (Complete sections 1- 12 and sections 14 – 26)	
2. Child/young person's Details	
Child/ Young Person's first name/s:	Child/young person's family name:
Date of Birth:	Is the child/young person (please circle) Male Female
Child/young person's Address:	First Language spoken by this child/young person/family :
Post Code:	Interpreter needed? Yes/No
3. What nursery / school /college does the child/young person attend?	
Name of School/Setting :	Telephone contact details of School/Setting ;
Address:	Name of person at the setting that is the best person for us to speak to :
	Current year group:
4. Parents/Carers details: Please give full names and addresses (if different) of each parent/carer responsible for this child/young person where applicable	
Name:	Name:
Mother Father Carer (please circle)	Mother Father Carer (please circle)
Address:	Address:
Post code:	Post code:
Contact Telephone Number Land line:	Contact Telephone Number Land Line:
Mobile: Can a message be left on these numbers? Yes/No	Mobile : Can a message be left on these numbers? Yes/No
Is this child/young person looked after by the local authority Yes / No (Please circle)	
Who holds parental responsibility for this child/young person?	

5. Referrer your details: (We need to know who is referring this child/young person)			
Name of person referring child/young person: Address of person referring child/young person: Post code:	Please tell us who you are e.g. parent, SENCo, GP etc. Telephone contact details:		
6. Date this form was completed:			
7. Details of the Child/Young Person's GP: (Check with us if you are not sure if this is a Solihull GP)			
Name of the GP/Practice: Address of GP Practice: Post code:	NHS number: Telephone Number of GP:		
8. PARENT'S CONSENT - In order for this referral to be considered, parents/carers or those with designated parental responsibility MUST give their signed consent.			
Please read, sign, print name and tell us who you are in the boxes below:		<i>Signature and date</i>	PRINT NAME and tell us who you are in relation to this child/young person.
<i>I am aware of the concerns outlined in this referral and consent to the further assessment of my child/young person's strengths and difficulties to be considered.</i>			
<i>I give my consent for further information to be requested from professionals currently or previously involved and if necessary, for this information to be discussed with the multi disciplinary team as part of the referral and assessment process.</i>			
9. Please tick as appropriate			
White British	<input type="checkbox"/>	Bangladeshi or British Bangladeshi	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	Other Asian Background	<input type="checkbox"/>
Other White Background	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>	African	<input type="checkbox"/>
White & Black African	<input type="checkbox"/>	Other Black Background	<input type="checkbox"/>
White & Asian	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Other Mixed Background	<input type="checkbox"/>	Other Ethnic Group	<input type="checkbox"/>
Indian or British Indian	<input type="checkbox"/>	Ethnic Category Not Stated	<input type="checkbox"/>
Pakistani or British Pakistani	<input type="checkbox"/>		<input type="checkbox"/>

10. Information about the child/young person

Does this child/young person have any known medical conditions or impairments?
(please include any allergies)

Describe the impact of these difficulties on the child/young person.

Is this child/young person currently on any medication? If so please detail:

Have they passed hearing checks?	Yes No Don't Know (please circle)
----------------------------------	------------------------------------

Have they passed vision checks?	Yes No Don't Know (please circle)
---------------------------------	------------------------------------

Does this child/young person wear glasses?	Yes No Don't Know (please circle)
--	------------------------------------

11. Child/young person's family details

Tell us about key family members, and who lives in the house with this child/young person.	
--	--

Do any other family members have any difficulties?	
--	--

12. Social Care information

Is the child/young person or family currently supported by Social Care?	Currently : Yes No Don't know (please circle)
---	---

Previously : Yes No Don't know (Please circle)
--

Name and contact details of social worker	Name:
---	-------

Address:

Tel:

Please tell us why this service is or was involved.	
---	--

Please only complete this page if you are referring a child with complex medical and/or developmental needs. If you are referring a child/young person for an assessment of a possible ASD please move to the section 14

13. Complex medical/developmental needs	
What are parent's current main concerns?	1. 2. 3.
Describe any physical strengths or difficulties that this child has	
Describe any communication strengths or difficulties that this child has	
Describe any play and interaction strengths or difficulties that this child has	
Describe any learning strengths or difficulties	
Tell us anything else about this child that you feel would be helpful for us to know	

Please remember to enclose all the information you hold from other professionals and services. It will delay the referral being considered if they are not included.

**14. Tell us about any additional support that this child/young person currently receives?
Please continue on a separate sheet if necessary**

Describe the additional support	Who is responsible for providing this support? Please include their contact details	When did this support start and how often does it occur?	What difference has it made?

15. Tell us about any additional support that this child/young person has previously received?

Describe the previous additional support	Who was responsible for providing this support?	When did this assistance start and how often did it occur?	What difference did it make?

Does the child/young person have a Statement of Special Educational Need or an Education Health Care Plan in place? YES NO

If you are referring a child with complex medical difficulties and/ or developmental difficulties please now go to sections 25 & 26 towards the end of this form and then return the completed form to the Specialist Assessment Service, Chelmsley Wood Primary Care Centre.

Please continue to complete the next sections of this form if you are referring a child/young person for difficulties that may indicate an Autism Spectrum Disorder

16. Describe any additional support parents/carers have received and also how strategies have been shared with parents/carers

What are parents/carers main concerns at the moment?

If the referrer is not the parent, please add in what are the referrers main concerns at the moment



17. Child/young person's views

Is the child/young person aware of this referral?
(we are aware that this may not be appropriate for young children)

YES

NO

What are their views about their strengths and any difficulties they may be experiencing? (we understand that this is not always possible to comment on for very young children)

Current strengths and difficulties	This column to be completed by Parents/carers 	This column to be completed by a key professional e.g. SENCO, ASD lead or referrer. 
18. Communication Skills		
Describe how well this child/young person understands what is said to them e.g. Can they follow instructions appropriate to their age.		
Does this child/young person follow routines of the household/classroom? Do they watch or follow other children to help them understand? Please describe.		
Describe how this child/young person expresses themselves and is it in a way that is appropriate to their age group?		
Can this child/young person use <ul style="list-style-type: none"> • Appropriate eye contact? • Facial expression? • Body posture? • Gesture? 		

<p>Describe how this child/young person responds to direct questions?</p>		
<p>Describe anything that you have noticed that's different about the way this child/young person speaks e.g. Tone or style of what they say, use of repetitive phrases, say things inappropriate to a situation or gives unusual or random answers to questions.</p>		
<p>Describe how this child/young person holds a two way conversation. Can they keep on topic, show interest in what people are saying, take turns in a conversation, dominate or get left out of conversations?</p>		
<p>Describe how this child/young person interacts, with child/young people their own age, with family members, with teachers, with unfamiliar people.</p>		

19. Play skills

Describe this child/young person's play skills e.g. do they seem appropriate for their age, do they play with others, does play lead to difficulties?

Can this child/young person play imaginatively?

Describe how this child/young person shares interests and their achievements with others

20. Flexibility of thought and behaviour

Describe any intense interests that this child/young person may have that have an impact on their day to day life.

Describe any unusual routines that this child/young person may have.

Describe how this child/young person copes with any changes to their routine and what you may have to do to help them cope.

<p>Describe this child/young person's behaviour.</p>		
<p>Describe any unusual or repetitive motor movements e.g. finger flapping or twisting or general body movements.</p>		
<p>Describe what may distress this child/young person or make them anxious.</p> <p>Tell us about what has to be put in place to help them manage their distress.</p>		
<p>Describe how this child/young person responds to other people's emotions.</p>		
<p>Describe if this child/young person is able to adjust their behaviour to different situations.</p>		

21. Sensory Information

<p>Describe if this child/young person is extra sensitive e.g. to noises, textures, touch, smell, movement.</p>		
<p>Does this child/young person seek additional sensation? If so, how? E.g. do they fidget, fiddle, touch, can't sit still?</p>		

22. Physical Skills and Independence

<p>Describe any strengths or difficulties with gross motor skills, balance or co-ordination.</p>		
<p>Describe any strengths or difficulties with fine motor skills e.g. handwriting, keyboard skills, drawing, painting, cutting.</p>		

23. Independence

<p>Describe if this child/young person can complete daily living skills as expected for their age?</p> <ul style="list-style-type: none">• Toileting• Dressing		
---	--	--

<ul style="list-style-type: none"> • Eating • Drinking • Attend to their own personal hygiene needs 		
24. Cognition and Learning		
<p>Can this /young person choose and complete an activity in a way appropriate to their age group?</p>		
<p>Can this child/young person maintain their attention in a way appropriate to their age group?</p>		
<p>Describe any concerns around this child/young person's learning?</p>		
<p>Do they have any particular strengths/difficulties in different subject areas?</p>		
<p>Is this child/young person meeting age related expectations across the national curriculum?</p> <p>If not , describe their attainment levels</p>		

25. Is there anything else that you would like to tell us about this child/young person to help us understand the complete picture? Continue on a separate sheet if necessary

Remember to include any information from school or from other professionals that you have. For parents/carers the school SENCo should be able to help you with this as it will be in your child/young person's school records.

26. Signatures of people providing the information	<i>Parents/Carers</i>	<i>Professional</i>
	Print name: Signature: Relationship to child: Date:	Print name: Signature: Relationship to child: Date:

Thank you for taking the time to complete the Specialist Assessment Service Referral Form.

The information provided will be considered at the Assessment panel. This is held fortnightly. We will then write to parents/carers to let them know the next steps for their child/young person and we will send copies of that letter to the key people involved with this child/young person.

Please remember if this child/young person does not have a Solihull GP, information is missing or if evidence does not go back over 6 months (or 2 terms) for children being referred for an ASD assessment, we are not able to accept a child/young person's referral.

Please send your completed referral form, along with any additional information to:

**Specialist Assessment Service, Administrator, Chelmsley Wood Primary Care Centre, Crabtree Drive, Birmingham B37 5BU.
Tel 0121-722-8010 Fax 0121-424 5916**

Service Clinical Lead: Shirley Heatherington