ASD Helping Hands
Room 412-416
Breckland Business Centre
St Withburga Lane
Dereham
Norfolk
NR191 FD

# Autism Information and Advice Service Referral Form

| **Main Contact Details**<br>*This is the person that we will contact regarding the referral* | | | | |
|---|---|---|---|---|
| First Name | | Surname | | |
| Email Address | | | | |
| Phone Number | | | | |
| **Address** | | | | |
| Street Address | | | | |
| City/Town | | County | | |
| Postcode | | | | |
| What are do you live in? | □ Kings Lynn & West Norfolk | | □ South Norfolk & Waveney | |
| | □ Norwich | | □ Broadland | |
| | □ Breckland | | □ North Norfolk | |
| | □ Great Yarmouth | | □ Other | |
| If other, please tell us your local council: | | | | |
| What is your relation to the person this referral is about? | □ Self-referral | | □ Parent | |
| | □ Grandparent | | □ Foster Carer / Legal Guardian | |
| | □ Spouse/ Partner | | □ Professional Relationship | |
| | □ Other | | | |
| If other, please tell us your relation the person this referral is about | | | | |

| **Who is this referral about?** | | | |
|---|---|---|---|
| First Name | | Last Name | |
| Date of Birth | | | |
| Address (If different from Main Contact) | | | |
| Street Address | | | |
| City/Town | | County | |
| Postcode | | | |
| School/College currently attending. Leave Blank if not applicable | | | |

| **Diagnosis** | | |
|---|---|---|
| Does the person have a confirmed diagnosis? | □ Yes | □ No |
| If Yes, what diagnosis | □ Autism Spectrum Disorder (ASD) | □ Attention Deficit Hyperactivity Disorder |
| | □ Pathological Demand Avoidance (PDA) | □Tourette's Syndrome |
| | □ Anxiety | □ Depression |
| | □ Other Mental Health condition | □ Learning Disability |
| | □ Sensory Processing Disorder | □ Other |
| | □ Learning Difficulties (Dyslexia, Dyspraxia, Dyscalculia etc) | |
| If other, please dive details | | |
| If No, please select the most appropriate statement | □ No Professional Involvement | |
| | □ GP Visited | |
| | □ Referred to Neurodevelopment service | |
| | □ Seen the Neurodevelopmental service once | |
| | □ Seen the Neurodevelopmental service twice or more | |
| | □ Awaiting outcome of Assessment | |
| | □ Using a private diagnostic organisation | |

| **Documents**<br>*Please include here any documents you think we will find helpful, such as Educational Health and Care plans, Letters of Diagnosis, or letters from services etc. Please only send photocopies no originals* | |
|---|---|
| Name of Document | |
| Name of Document | |
| Name of Document | |
| Name of Document | |
| Name of Document | |

| **Professionals Involved**<br>*Please include any details here of professionals or organisations that are already involved.* | | | |
|---|---|---|---|
| Professional 1 | | | |
| Name | | Organisation | |
| Email | | Phone | |
| Professional 2 | | | |
| Name | | Organisation | |
| Email | | Phone | |
| Professional 3 | | | |
| Name | | Organisation | |
| Email | | Phone | |
| Professional 4 | | | |
| Name | | Organisation | |
| Email | | Phone | |

| **Reason for Referral**<br>*Please give us as much information as possible as to the reason for this referral. It can be helpful to give us an overview of the current situation, what difficulties you are facing and how you would like to be supported to overcome these. Please use additional sheets if required.* |
|---|
| |

By completing and submitting this referral form I agree for ASD Helping Hands to hold my details on their records to assist them with managing the support and communication they have with me.

For more information on how we store and use your data please read our Privacy Policy which is available on our website: https://www.asdhelpinghands.org.uk/privacy-policy-2/

Please send you completed referral forms to:

ASD Helping Hands

Breckland Business Centre Room 412-416

Dereham

Norfolk

NR19 1FD

| Office Use | |
|---|---|
| Referral received | |
| By whom | |