

**DEVON ADULT AUTISM AND ATTENTION DEFICIT HYPERACTIVITY DISORDER (DAANA) SERVICES *(for people 18 or over)***

**Referral Form for General Practitioners**

At the Devon Adult Autism and ADHD Service (DAANA) we provide diagnostic assessments for adults who may have autism spectrum conditions (ASCs). Please note that we do not accept self-referrals, and that the form below needs to be completed by a clinician.

For further information on how to complete a referral, please see our guidance notes on our website: <https://www.dpt.nhs.uk/our-services/adult-autism-and-adhd/what-is-autism>

**We can only accept referrals for individuals who:**

* **Are aged 18 or over**
* **Are registered with a GP surgery in Devon (excluding Plymouth)**
* **Do not already have a diagnosis of an autism spectrum condition**

Please note that **we are unable to manage any mental health needs the client may have whilst they are waiting for an assessment.** If you think that your client needs support regarding their mental health please ensure they access the appropriate services whilst waiting for an assessment. Furthermore **we are primarily a diagnostic service**. As such, support for comorbid mental health conditions will need to be provided by other mental health services

Should you feel that your client would benefit from an assessment of their social care needs, please see our guidance notes on our website for more information. Please note that a diagnosis of an autism spectrum condition is not necessary to access social care.

**Please attach any copies of relevant reports or letters.**

**Date: …………………..**

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| **DAANA Services:****Please complete this form if you are requesting a diagnosis of an Autism Spectrum Condition (ASC) including Asperger’s Syndrome*****Please note there is a separate form for referrals regarding ADHD*** |
| **PATIENT DETAILS** |
| **Name:Date of birth:**  | **NHS No:Marital Status: ………………………..**  |
| **Gender: □M □ F □ Other (please specify): ………………………..****Ethnicity: □ British □ Other (please state): ………………………..** |
| **Address:** **Postcode:** | **Telephone number:****Occupation:** |
| **Please tick to confirm the following:****The patient has given informed consent for this referral**  |  |
| **GP INFORMATION** |
| **Name of GP:** **Name of surgery:** **Telephone number:**  | **Surgery address:**  |
| **REASON FOR REFERRAL** |
| **Please outline the reasons for your referral, describing the impact upon the patient’s day to day life:** |
| **EARLY DEVELOPMENT****Please indicate if you are aware of any concerns raised during the individual’s childhood regarding language development, developmental milestones, social difficulties, behavioural concerns:** |

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| **PLEASE NOTE: In order for us to accept a referral for an individual to have an assessment, we must have evidence of possible differences related to the autism spectrum in both of the areas below.** **Social interaction and communication**Please describe, and give examples of, any differences or difficulties relating to social interactions and communication, for example in relation to friendships and relationships; social interactions; understanding others’ emotions and behaviour; verbal and non-verbal communication. Please also include any comments on your experiences of the client’s communication.**1)****2)****3)****Restricted, repetitive patterns of behaviour, interests, or activities**Please describe, and give examples of, any differences or difficulties relating to restricted or repetitive behaviours or interests, for example in relation to the topic and intensity of interests; routines and rituals; ability to cope with change; repetitive behaviours; rigidity of thoughts or behaviour; sensory sensitivities.**1)****2)****3)**  |
| **OTHER PHYSICAL OR MENTAL HEALTH CONDITIONS** |
| **Please provide information about any current or previous relevant physical and mental health diagnoses:**  |

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| **REASONABLE ADJUSTMENTS** |
| **Please detail any reasonable adjustments that the individual may require to help them access our service (this could include interpreters, easy-read information, shortened appointments etc.)** |

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| **RISK** |
| **Please detail any information or concerns regarding risk (to the individual themselves, or from the individual to others) that we should be aware of prior to an assessment:*****Please note: we are not able to manage risk while an individual is on our waiting list. If you have concerns, these should be managed by other services/professionals involved in the individual’s care.*** |

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| **FOR ASC/ADHD TEAM USE ONLY** |
| **Screening:** **Date screened: …………………………………............****Screened by: ………………………………..................** |
| **Outcome:** |

**Please send the completed form to** **dpn-tr.ASC@nhs.net** **or:**

**DAANA Team, Devon Adult Autism and ADHD Service, 2nd Floor, Forde House, Park Five,**

**Harrier Way, Exeter, EX2 7HU.**