*Clinician’s Toolkit*

**ASD Assessment Planning Tool**

**Personal Details**

|  |  |
| --- | --- |
| Name | DOB |
| Address | Hospital Number |
| Parent Carer Details |
| School | Referred by |
| Other relevant information |

# **Review of referral**

|  |  |  |
| --- | --- | --- |
| Referral date: | Date received: | Date discussed: |
| Referral reviewed by: |
| **Content** | **Yes / No** |
| Are there clear signs / symptoms of ASD? |  |
| Is regression in skills or language noted? |  |
| Are symptoms pervasive? |  |
| Have symptoms been present over time? |  |
| Are symptoms impacting on daily life? |  |
| Are risk factors for ASD present? |  |
| Are parental concerns noted? |  |
| Are school concerns noted? |  |
| Are medical professional concerns noted? |  |
| Was a tool used to assess symptoms? |  |
| **Previous Interventions** | **Yes / No** |
| Has child been assessed previously? |  |
| Is child known to social services? |  |
| Is child known to child health? |  |
| Is child known to CAMHS? |  |
| Is child known to SaLT? |  |
| Is child known to OT? |  |
| Is child receiving additional educational support (statutory or non-statutory) |  |
| Outcome |
| Decline referral 🞏 |
| Reason: | Allocated to: | Timescale: |
| Seek further information before reaching decision 🞏 |
| Reason: | Allocated to: | Timescale: |
| Accept and proceed with assessment 🞏 |

# **Assessment Action Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Component** | **Required?** | **Allocated to** | **Timescale** |
| Paediatric Assessment |  |  |  |
| CAMHS assessment |  |  |  |
| SaLT assessment |  |  |  |
| OT assessment |  |  |  |
| Educational Psychology assessment |  |  |  |
| School observation |  |  |  |
| Home observation |  |  |  |
| ADOS |  |  |  |
| ADi-R |  |  |  |
| 3Di |  |  |  |
| DISCO |  |  |  |
| Other: |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# **Further Information from External Agencies Required:**

|  |  |  |
| --- | --- | --- |
| **Information to be sought from:** | **Allocated to:** | **Timescale:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# **Assessment Discussion**

|  |
| --- |
| **Summary:** |
| **Outcome:**  |
| Meets criteria for ASD diagnosis  |  |
| Does not meet criteria for ASD  |  |
| Unable to reach decision further assessment / information required  |  |
| ASD assessment complete, assessment for other issues required  |  |