

# Integrated Autism Service

## Referral Form for Diagnostic Assessment of Autism



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Cwm Taf Morgannwg  
University Health Board



If you are an adult (over 18 years old) and think you are autistic, but do not have a formal diagnosis, the Integrated Autism Service (IAS) will be able to offer you a diagnostic assessment. This referral form can be completed by the person requesting an assessment (self-referral), or by a family member, friend, or if you are seeing a health professional, such as a GP, you could ask them to complete this referral form for you.

### Section 1: Service User Details

Forename(s):  Surname:

Title:  Gender:  Pronouns:

Address:  DOB:

NHS No:

Hospital No:

Telephone:  Email:

Ethnic Origin:  Preferred Language:

Preferred method of communication:  Telephone  Letter  Email  Text

**If this is a self-referral, go to Section 3.**

### Section 2: Referrer Details (if this is a self-referral, please leave this section blank)

Name:  Profession/Role:

Address:  Telephone:

Email:

Relationship to person seeking diagnostic assessment:

Have you discussed this referral with the service user?  Yes  No

*Please note, referrals will not be accepted with without informed consent. Please advise the service user that the IAS is a multi-agency team and information may be accessed by both local authority and health staff.*

### Section 3: GP Details (if the GP is not the referrer)

GP Name:  GP Practice:

Telephone:  Email:

Address:

### Section 4: Other Professionals Involved

	Name of Professional	Service	Contact Details
1.			
2.			
3.			
4.			
5.			

**Section 5: Background** (please complete each of the following sections in as much detail as possible)

**Tell us about your developmental history**

*(e.g. delays in meeting developmental milestones, such as speech; loss of skills that had been acquired; unusual behaviour in childhood; differences in interaction and communication; additional educational needs etc.)*

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**Section 6: Social Communication**

**Difficulties making/keeping friendships**

NOW:

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IN CHILDHOOD:

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**Understanding of emotions in yourself and others**

NOW:

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IN CHILDHOOD:

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**Understanding/ using social rules**

NOW:

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IN CHILDHOOD:

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**Unusual speech, e.g. flat, differences with managing volume etc.**

NOW:

IN CHILDHOOD:

**Use and understanding of non-verbal communication, e.g. eye contact, facial expressions, gestures, body language etc.**

NOW:

IN CHILDHOOD:

**Conversations; to and fro of conversation, social interest in others, literal understanding etc.**

NOW:

IN CHILDHOOD:

**Section 7: Restricted/Repetitive Behaviours**

**Highly focused/ intense interests**

NOW:

IN CHILDHOOD:

**Repetitive behaviours, e.g. movements or verbal**

NOW:

IN CHILDHOOD:

**Coping with change**

NOW:

IN CHILDHOOD:

**Strong adherence to specific routines, rituals or have to do things in a specific way**

NOW:

IN CHILDHOOD:

**Inflexible thinking, e.g. finding it difficult to see things from someone else's perspective**

NOW:

IN CHILDHOOD:

**Section 7: Please provide information on the following**

**Have you experienced any problems finding or keeping education or employment?**

**Have you had any contact with mental health, learning disabilities or neurodevelopmental services?**

**CURRENT:**

**IN THE PAST:**

**Please provide any information on other diagnoses, e.g. depression, personality disorder, ADHD etc.**

**Please specify any documentation that you may have enclosed with this referral, e.g. psychology reports, school reports, statement of educational needs, etc.**

**Please comment on any relevant issues relating to risk, e.g. adult/child protection, criminal justice system/convictions or pending convictions, alcohol/drug dependency, suicidal thoughts/self-harm etc.**

**Any additional relevant information, including any help or adjustments you need when accessing the service:**

**Why is a diagnostic assessment for autism being considered at this time and whose idea was it?**

**Section 8: Consent (this section must be signed and dated to consent to the referral)**

I do /  I do not (please tick one) consent to my information being recorded and used by IAS professionals to help them understand the support I need.

I do /  I do not consent to my information being included within anonymised data, which will be shared with external partners, e.g. Welsh Government, local authorities, for the purpose of monitoring and evaluation of the IAS and future planning of services.

I understand that my information may need to be shared with other agencies to ensure I get the most suitable support for me. Please indicate in the table below what agencies you do/do not give consent for IAS to share information with.

	Consent	Do not consent
General Practitioner (GP): .....	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services: .....	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disabilities: .....	<input type="checkbox"/>	<input type="checkbox"/>
Social Services: .....	<input type="checkbox"/>	<input type="checkbox"/>
Employer: .....	<input type="checkbox"/>	<input type="checkbox"/>
Family: .....	<input type="checkbox"/>	<input type="checkbox"/>
Education: .....	<input type="checkbox"/>	<input type="checkbox"/>
Relevant private sector or third-party organisations who may carry out a diagnostic assessment on behalf of CTM IAS.	<input type="checkbox"/>	<input type="checkbox"/>
If you consent, do you have access to a laptop or tablet? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other (please specify): .....	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Service User: <input style="width: 90%;" type="text"/>	Date referral completed: <input style="width: 90%;" type="text"/>
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Please send the completed referral form to:

✉ Integrated Autism Service  
 Floor 2  
 Keir Hardie Health Park  
 Aberdare Road  
 MERTHYR TYDFIL  
 CF48 1BZ

✉ [CTT\\_IAS@wales.nhs.uk](mailto:CTT_IAS@wales.nhs.uk)

☎ 01443 715044

🌐 [www.ctmuhb.nhs.wales/services/integrated-autism-service-ias](http://www.ctmuhb.nhs.wales/services/integrated-autism-service-ias)

**What happens next?**

The referral will be discussed in the weekly multidisciplinary team meeting (MDT). If the referral meets the criteria for an autism assessment, a letter will be sent to the service user notifying them that their referral has been accepted and that they have been placed on the waiting list.

When the referral reaches the top of the waiting list, the service user will be sent an opt-in letter and two questionnaires prior to the assessment; the pre-assessment questionnaire is for the service user to complete and the informant questionnaire is for someone who has known the service user really well from a young age to complete (such as parent, grandparent, sibling, friend or partner).

When the completed questionnaires are returned to the IAS, the service user will then be invited for a diagnostic assessment. The informant (the person who completed the informant questionnaire) will be required to attend part of the appointment.

Following the assessment, you will be offered advice about the next steps and provided with an assessment outcome report and recommendations.