

**Doncaster Adult Neurodevelopmental Service (DANS)**

**REFERRAL FORM**

(October 2022)

**Please check our referral criteria below to ensure your referral is appropriate for our service as this will avoid unnecessary waiting times for the client.**

**Acceptance criteria**

* Adults (aged 18+)
* Registered with a Doncaster GP
* ADHD / ASD - seeking assessment
* Adults with an ADHD diagnosis requiring ADHD medication treatment initiation or review
* Referral supported by professional / clinical opinion

**Exclusion criteria**

* Aged below 18 years
* Not a Doncaster resident (without ICB funding)
* Clients currently experiencing an episode of psychosis
* No consent from patient for the referral

**Please answer all questions fully and complete all symptom and impairment screening questionnaires prior to sending the referral.**

**We cannot accept self-referrals, please ensure your clinical opinion is detailed in the referral for it to be accepted.**

**Referrals will not be processed unless all relevant sections are completed.**

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| **Patient Name:** | | | | | **Date of Birth:** | | | **NHS Number:** | |
|  | | | | |  | | |  | |
| **Gender identity:** | | | | | **Pronouns:** | | | **Email Address:** | |
|  | | | | |  | | |  | |
| **Address:** | | | | | | | | **Contact Number:** | |
|  | | | | | | | | **Mobile:** |  |
| **Telephone:** |  |
| **Marital Status:** | | | | | | | **Ethnicity:** | | |
|  | | | | | | |  | | |
| ***Reason for Referral: (Tick as appropriate, then complete the appropriate section)*** | | | | | | | | | |
| 1. **ADHD Assessment** | | | | | | 1. **ADHD Medication Treatment** | | **3. Autism Diagnostic Assessment** | |
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| **Person making the referral:**  *Name, position and contact details* ***(stamp if available)*** | | | | | | | | | |
|  | | | | | | | | | |
| **Has the patient consented to this referral? (Tick as appropriate)** | | | | | | | | | |
| **Yes** |  | **No** |  | **We cannot process the referral without the consent of the patient** | | | | | |
| **GP Details:** | | | | | | | | | |
|  | | | | | | | | | |
| **Existing Neurodevelopmental, Psychiatric, or physical health diagnosis:** | | | | | | | | | |
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| **Current Medication:** | | | | | | | | | |
|  | | | | | | | | | |
| **Substance Use / Misuse** | | | | | | | | | |
|  | | | | | | | | | |
| **Forensic History:** | | | | | | | | | |
|  | | | | | | | | | |
| **Current Risks:** | | | | | | | | | |
| Is the person vulnerable to risk? (e.g., self - neglect, physical health, physical, sexual, or financial abuse)?  NO:  YES:  Please give details:  Does the person pose a known risk to other people (e.g., property damage, physical harm, sexual harm)?  NO:  YES:  Please give details:  Does the person pose a known risk to staff and professionals? Is an escort needed in clinic?  NO:  YES:  Please give details:  Does the person live in a household with children under the age of 18 years or have substantial access to their own or other children under the age of 18 years?  NO:  YES:  Please give details:  Are there any known Safeguarding Children issues that you are aware of?  NO:  YES:  Please give details: | | | | | | | | | |

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| 1. **ADHD Diagnostic Assessment**   **PLEASE ONLY FILL THIS SECTION IN IF YOU ARE REFEFFERING FOR ADHD ASSESSMENT** |
| ***Examples of inattention, hyperactivity, or impulsivity including current and childhood history if symptoms.***  ***Several symptoms must be present in at least two different settings (i.e., home, work or with friends / relatives)*** |
| **Attention and Concentration?** |
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| **Organisation Skills?** |
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| **Restlessness, difficulty keeping quiet, irritability / frustration?** |
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| **Have the above difficulties been long standing? (i.e., since childhood or adolescence)** |
|  |
| **Additional Information** |
|  |
| **Cardiac Issues:** *Include information on all cardiac issues i.e., family history; please rule out any heart murmurs, palpitations & chest pains. (Please note this referral will be rejected if not completed)* |
|  |

**Please complete for ADHD only**

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| ASRS V1.1  **Part A** | Never | Rarely | Sometimes | Often | Very often |
| How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? |  |  |  |  |  |
| How often do you have difficulty getting things in order when you have a task to do that requires organisation? |  |  |  |  |  |
| How often do you have problems remembering appointments or obligations? |  |  |  |  |  |
| When you have a task that requires a lot of thought, how often do you avoid or delay getting started? |  |  |  |  |  |
| How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? |  |  |  |  |  |
| How often do you feel overly active and compelled to do things, like you were driven by a motor? |  |  |  |  |  |
| **Part B** |  |  |  |  |  |
| How often do you make careless mistakes when you have to work on a boring or difficult project? |  |  |  |  |  |
| How often do you have difficulty keeping your attention when you are doing boring or repetitive work? |  |  |  |  |  |
| How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? |  |  |  |  |  |
| How will often do you misplace or have difficulty finding things at home or at work? |  |  |  |  |  |
| How often are you distracted by activity or noise around you? |  |  |  |  |  |
| How often do you leave your seat in meetings or other situations in which you are expected to remain seated? |  |  |  |  |  |
| How often do you feel restless or fidgety? |  |  |  |  |  |
| How often do you have difficulty unwinding and relaxing when you have time to yourself? |  |  |  |  |  |
| How often do you find yourself talking too much when you are in social situations? |  |  |  |  |  |
| When you are in a conversation, how often do find yourself finishing the sentences of other people you are talking to, before they can finish themselves? |  |  |  |  |  |
| How often do you have difficulty waiting your turn in situations when turn taking is required? |  |  |  |  |  |
| How often do you interrupt others when they are busy? |  |  |  |  |  |

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| 1. **ADHD Medication Treatment** |
| ***We will require evidence of existing ADHD diagnosis.***  ***Please detail any current medication and dose, as well as any relevant treatment history (what has been tried, dose and any side effects).*** |

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| 1. **Autism Diagnostic Assessment**   **PLEASE ONLY COMPLETE THIS SECTION IF YOU ARE REFEFFERING FOR AN AUTISM ASSESSMENT** |
| **Summary of Difficulties**  *(The characteristics of autism are generally divided into three main groups - examples given). Please use the tick boxes and add any additional information where necessary*   1. **Social Communication**   ☐ Difficulty with verbal and non-verbal communication (avoiding eye contact/diff. understanding facial expressions).  ☐ Difficulty starting/maintaining/give-and-take of conversation, literal understanding of language,  ☐ Difficulty understanding jokes/sarcasm.   1. **Social interaction**   ☐ Difficulty understanding other’s emotions/point of view.  ☐ Difficulty fitting in socially.  ☐ Difficulty initiating and maintaining relationships.  ☐ Preferring to spend time alone, finding people confusing/unpredictable.   1. **a) Routines/Rituals; b) Highly focussed and intense interests; c) sensory sensitivities**   ☐ Fixed daily routines  ☐ Uncomfortable with change, cope better with preparation  ☐ Intense interest in specific, highly focussed areas of interest  ☐ Hyper-/hyposensitive to one or more senses   1. **Have the above difficulties been long standing (i.e., since childhood)?**   ☐ Yes  ☐ No  ☐ Don’t know  Additional Information |

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| **Specific Concerns related to ASD** |
| **Development -** Were there any delays in early development, such as in learning to speak?  Please give details. |
| **Social functioning -** Is there significant difficulty in interacting with others, such as family, peers, or strangers? Are there any difficulties in communication with others? Please give details |
| **Interests/leisure activities -** Does the service user have particular interests or activities that they dedicate a large amount of time? Please give details. |
| **Daily living -** How independently is the person able to live? Is any assistance with daily living tasks, such as cooking, cleaning, going out in the community, or managing finances required? |



**AQ-10**

**Autism Spectrum Quotient (AQ)**

A quick referral guide for adults with suspected autism who do not have a learning disability.

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| --- | --- | --- | --- | --- | --- |
|  | **Please tick one option per question only:** | **Definitely agree** | **Slightly agree** | **Slightly disagree** | **Definitely disagree** |
| 1 | I often notice small sounds when others do not. |  |  |  |  |
| 2 | I usually concentrate more on the whole picture, rather than the small details. |  |  |  |  |
| 3 | I find it easy to do more than one thing at once |  |  |  |  |
| 4 | If there is an interruption, I can switch back to what I was doing very quickly |  |  |  |  |
| 5 | I find it easy to ‘read between the lines’ when someone is talking to me |  |  |  |  |
| 6 | I know how to tell if someone listening to me is getting bored |  |  |  |  |
| 7 | When I’m reading a story I find it difficult to work out the characters’ intentions |  |  |  |  |
| 8 | I like to collect information about categories of things (e.g. types of car, bird, train, plant etc.) |  |  |  |  |
| 9 | I find it easy to work out what someone is thinking or feeling just by looking at their face |  |  |  |  |
| 10 | I find it difficult to work out people’s intentions |  |  |  |  |

**SCORING:** Only 1 point can be scored for each question.*Score 1 point for Definitely or*

*Slightly agree on each of items 1, 7, 8, and 10. Score 1 point for Definitely or Slightly Disagree on each of items 2, 3, 4, 5, 6, and 9.* If the individual scores**more than 6 out of 10**,consider referring them for a specialist diagnostic assessment.

This test is recommended in ‘Autism: recognition, referral, diagnosis and management of adults on the autism spectrum’ (NICE clinical guideline CG142). www.nice.org.uk/CG142

**Key reference:** Allison C, Auyeung B, and Baron-Cohen S, (2012)*Journal of the American Academy**of Child and Adolescent Psychiatry* 51(2):202-12.



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| --- | --- |
| **Referrer checklist:** | **Tick** |
| Referral form fully completed with clinical opinion from referrer |  |
| ASRS completed and scored (ADHD) |  |
| AQ-10 completed and scored (ASD) |  |
| Proof of existing ADHD diagnosis (if applicable) attached |  |
| Client has consented to the referral |  |

**If you have any further queries regarding the completion of this form, please contact the service by telephone on 03000 212878.**

**Please return completed forms to:**

Doncaster Adult Neurodevelopmental Services (DANS)

2 Jubilee Close

Tickhill Road Hospital

Tickhill Road

Balby

Doncaster

DN4 8QN

Or by email: [RDASH.AdultLDServices@nhs.net](mailto:RDASH.AdultLDServices@nhs.net)