|  |  |  |
| --- | --- | --- |
| **Office Use** | | |
| **FP** | Prof | Parent |
| Label | Email | XL |



Referral Form

For children aged   
13 and under

Please complete ALL sections. Incomplete forms will be returned to you, to be fully completed

**Part A. Child and Family details**

|  |  |
| --- | --- |
| **Date:** | ***(DD/MM/YYYY)*** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Person on Autism Spectrum** | **Details of person on the Autism spectrum  NOTE: A separate form must be completed for each person on the autism spectrum** | | | | | |
| **Legal First Name(s)**  **(*as shown on birth certificate*)** | | **Legal Surname**  ***(as on birth certificate)*** | | **Date of Birth**  ***(DD/MM/YYYY)*** | |
|  | |  | |  | |
| **Name known as** (if different to above) |  | **Sex** | **Male  Female** | | |
| **Optional: *my child identifies their gender as***  ***and/or their preferred pronoun is:*** | | | |
| **Diagnosis:** | | **Diagnosed By (Clinic and person):** | | **Date of Diagnosis:** | |
|  | |  | |  | |
| **Name of nursery/School etc** | | Are they currently attending school/nursery? | | | **Yes  No** |
|  | | **If they are not attending, please give details in the**  ***Other* *Information* section** | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Ethnicity** | |  | |  | |  |  |  | |  |  | |  |  | | White British  White Irish  White European  Other White background \*  Gypsy/Roma |  | | Caribbean  African  Any other Black background\*  Traveller of Irish heritage | | |  | Indian  Pakistani  Bangladeshi  Other Asian background \*  Traveller of other heritage | |  | White & Black Caribbean  White & Black African  White & Asian  Other mixed background\* | |  | Chinese  Any other ethnic group \*  Not given |  | | **\* If other, please specify:** | | | | |  | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Parent / Carer** | **Name of Parent(s) / Carer** | | | Relationship to child with autism | Do they live at the family home? | | Is s/he on the   autism spectrum? | **Telephone**: | |
| 1. | | |  |  | |  | Home:  Mobile: | |
| 2. | | |  |  | |  | Home:  Mobile: | |
| **Home address and** **Email** for correspondence to parent(s)/carer **Please ensure you provide an email address for a parent/carer.** Our main method of communication is email, which helps save us additional costs. Our bulletins and newsletters about services, events, holiday activities and training courses are sent by email only. Please provide an email address if you have one. | | | | | | | | |
| **Primary Home Address including postcode** | | | | **Other Home Address (if applicable) inc. postcode** | | | | |
|  | | | |  | | | | |
| **Email** |  | | | **Email** |  | | | |
| **Permission to add you to our mailing list?** | | **Yes  No** | | **Permission to add you to our mailing list?** | | | | **Yes  No** |
| **Does the child reside at this address?** | | **Yes**   **No** | | **Does the child reside at this address?** | | | | **Yes  No** |
| Any comments: | | | | Any comments: | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **District Council** | Oxford City  Cherwell  West  Vale of White Horse  South | | | |
| **Language spoken at home** | |  | **Interpreter required?** | **Yes**   **No** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family** | **List of household members and other people important to the child** | | | |
| Name | Relationship to child: | DOB of siblings | Diagnosis? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please state any useful information that our staff may need before a meeting**  **Please note: All responses are treated sensitively** | | | |
| Is there an historic or current use of drugs/alcohol in the household. If yes, please explain. | |  | |
| Is anybody currently under police caution or have previous interaction with the criminal justice system? If yes, please explain | |  | |
| Is there a current Child Protection Plan? | Yes No | Is there a current Child in Need Plan? | Yes  No |
| Are there any other Child protection concerns? If so, please provide evidence | |  | |
| Is there a history of, domestic abuse? If yes, please explain if this is historic or ongoing. | |  | |
| Is there currently, or has there been, a history of mental health issues? | |  | |
| Any other known risks to staff - please specify | |  | |
| **Other Information:** Please provide relevant information which may help us with your referral – this may include current difficulties, family background, areas of concern. Include any support networks (such as parent support groups)that you use. | | | |
|  | | | |
| **Ideally what advice, support or service would you like us to provide?** | | | |
|  | | | |
| **Thoughts and concerns of the young person: *(please explain if they are unable to do so)*** | | | |
|  | | | |

|  |  |  |
| --- | --- | --- |
| **Professionals supporting you and your family – please tell us of professionals who are currently supporting the child/family**  **NOTE: If you are a professional completing this form please go to Part B** | | |
| Name | Job Title | Organisation & Contact details |
|  |  |  |
|  |  |  |
|  |  |  |

**Part B. To be completed by the professional making this referral only (if relevant)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Professional Referral** | **If you are a professional making this referral please provide your details** | | | | | | | | |
| **Name** | | | | **Job Title** | | | **Organisation and Address** | |
|  | | | |  | | |  | |
| **Tel: Office** | |  | |
| **Mobile** | |  | |
| **Email** |  | | | | | | | |
| Are you currently actively supporting the young person/family? | | | | | **Yes  No** | | | |
| If Yes please give details: | | | | | | | | |
| Reason for Referral: | | | | | | | | |
| **Other Professionals involved – please tell us of other professionals who are supporting the child/family** | | | | | | | | |
| **Name** | | | | **Job Title** | | | **Organisation & Contact details** | |
|  | | | |  | | |  | |
|  | | | |  | | |  | |
|  | | | |  | | |  | |

**Part C. Signature and Date**

|  |  |  |  |
| --- | --- | --- | --- |
| **How did you hear about Autism Family Support Oxfordshire?** (Please ‘X’ all that apply) | | | |
| From the Diagnostic clinic  School/college CAMHS  Other professional A talk/training  Someone who uses our service  Online search  Other: | | | |
| **Communication from us.** We send parents/carers news about our work and events, and other information which may be of interest. Please tell us if you agree for us to communicate with you (please ‘X’ **ALL** that you agree to) | | | |
| **YES I agree to communication BY EMAIL:**  **TELEPHONE/TEXT:**  **POST:** | | | |
| **Use of Data**: In completing this form you are agreeing for the information contained within to be held by Autism Family Support Oxfordshire (AFSO), and for AFSO to contact you if required. All information will be treated in strict confidence in accordance with UK Data Protection law. Oxfordshire County Council (OCC) fund some of our services and to monitor the impact & need of their support they contractually require us to provide to them your child’s name and date of birth if you have accessed the following: advice surgery, home visit, youth group, holiday activity. Information is not shared with other organisations unless we have permission, or it is necessary to do so to protect a child or adult. If you have any questions, please contact us for more information | | | |
| **Signature (OR type name)** |  | **Name** |  |
| **Relationship to young person** |  | **Date** |  |

**Please email this form to** **our Administrator, Judith Payne, at**: [**judith@afso.org.uk**](mailto:judith@afso.org.uk)( 01235 754700