Referral Form

Your Name: ______________________________

Address: ______________________________

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Date of Birth (if self-referral): ______________________________

Tel No & E mail: ______________________________

Date: ______________________________

Are you making a referral on behalf of someone else? **Yes/No** (please circle)

If yes, is the person aware you are making this referral? **Yes/No** (please circle)

If so what is their name? ______________________________

What is their Date of Birth? ______________________________

Their address (if different from above): ______________________________

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Telephone Number & Email: ______________________________

What is your relationship with this person? ______________________________

Which school (if any) does he/she attend? ______________________________

Which school year is he/she in? ______________________________

Are you (if self-referral) or the individual being referred diagnosed with one of the following conditions:

- ☐ Classic Autism
- ☐ High Functioning Autism
- ☐ Asperger Syndrome
- ☐ Atypical Autism
- ☐ Undiagnosed (suspected autism)

  Are you/they looking to seek a diagnosis? Y/N

Do you (if self-referral) or the individual being referred have any health issues e.g. hayfever, phobias or allergies?

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How did you hear about Autism Guernsey? ______________________________________

Please provide reasons for making a referral (continue on reverse or separate sheet if needed). This section will provide us with some useful background information:

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Please detail up to five examples of the kind of support you feel would benefit you (if self-referral) or the individual being referred:

1. ____
2. ____
3. ____
4. ____
5. ____

Please provide **names and phone numbers** of any professionals in the services/organisations listed below which are currently involved in your (if self-referral) or the individual's life:

GP (Name & tel no)	School Nurse	Special Educational Needs Co-Ordinator	Social Worker	Educational Psychologist
Clinical Psychologist	Child Mental Health Services	Speech and Language Therapist	Occupational Therapist	A Supported Employment Service
Family Proceedings Advisory Service	Paediatrician	Communication and Autism Service	Adult Mental Health Services	Other agencies/ Professionals/ Charities

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Autism Guernsey adheres to confidentiality data protection principles. Personal data will be used only for the aims and purposes that the organisation has specified and for which it has been established.

Do we have your permission to speak to any of the above should it be necessary? **Yes/No** (please circle). If possible please provide name and phone number of professional concerned.

Would you be prepared to provide some anonymous feedback? **Yes/No**
If 'No' this will not preclude you from receiving any support form Autism Guernsey.

Are there any risk factors we should consider when visiting you? E.g. large dogs.

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How would you like to be contacted in the first instance?

Telephone ☐ Email ☐

Signature: ……………………………………………………………………

Please return completed form to: Autism Guernsey, First Floor (East), La Grande Rue, St. Martin's Guernsey GY4 6RU. New referrals are reviewed on a six weekly basis, one of our staff will then contact you to respond to your referral.

Autism Guernsey is a CHARITY and receives no funding from Statutory Services. We provide a range of services, however this is dependent on available resources at any one given time.

Would you like to receive information regarding autism related news, training, fundraising events and quarterly newsletters? **Yes/No** (please circle)