Neurodevelopmental Service Referral Form A

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| Name of Child/Young Person |  |
| Date of Birth |  |
| Biological sex at birth (if now different please state) |  |
| Address |  |
| Telephone number |  |
| Email address |  |
| ND/ASD/ADHD (please state the reason for the referral) |  |
| IDP statement |  |
| Name of person making the referral & completing this form |  |
| Relationship to child/young person |  |
| Address |  |
| Telephone number |  |
| Email address |  |

Questions

1. What do you hope to gain from the child/young person being assessed by the ND service?
2. Is the issue having a significant and ongoing impact on the child’s everyday life? (For example: low motivation, poor self-care, poor sleep)
3. Is the problem affecting more than one part of the child’s life? (For example: school, home, friendships and leisure)
4. What are your main concerns about the child/young person’s difficulties?
5. What are the child/young person’s strengths? (For example: interests, educational, personality)
6. Why are you seeking assessment now?
7. Has the child/young person given consent to the assessment? (If they are older than 16 years old, explicit consent must be gained)