**Parent/ Carer/ Guardian OPT In/ Consent Form**

The Neurodevelopmental Service may contact other professionals involved in your child’s/young person’s care to obtain information and may also need to share information obtained about your child/ young person with other professionals.

**This includes education, health professionals, children’s services including: Child Health and Disability team and third sector agencies. This list is non-exhaustive.**

By completing this form you are confirming that you would like your child/young person to be assessed by the Neurodevelopmental Service and you are consenting for the service to share or obtain information.

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| PERSONAL INFORMATION | |
| Child’s/Young Person’s Name: |  |
| Date of Birth: |  |
| Biological sex at birth (if now different please state): |  |
| Home Address: |  |
| Contact Number(s) | Home: |
| Mobile: |
| Contact Email: |  |
| SCHOOL INFORMATION | |
| Nursery/School/College Name & Address: |  |
| Telephone Number: |  |
| Contact Name: |  |
| CONSENT (please tick) | |
| I would like an appointment for my child/young person with the Neurodevelopmental Service. |  |
| Has the child/young person given consent to the assessment? If they are older than 12 years old, explicit consent must be gained. |  |
| I would be happy to have the appointment by video link. |  |
| I give consent for questionnaires to be sent to my child’s/young person’s nursery/school/college. |  |
| I agree to you obtaining information from other professionals involved in my child’s/young person’s care.  This may include Educational Professionals carrying out school observations. |  |
| I agree to you sharing information from other professionals involved in my child’s/young person’s care. |  |
| Parent/Carer/Guardian Name (person completing this form): |  |
| Relationship to child/young person: |  |
| Signed: |  |
| Date: |  |

**Parent/Carer Questionnaire**

**To help us consider how to best manage your child’s/young person’s referral, please can you answer as fully as possible.**

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| Who does the child/young person live with (please list all family members in household and ages and relationships to child, e.g. sister, mother, step-father)? |  |

**Is there any family history of Neurodevelopmental conditions (ADHD, Autistic Spectrum Disorder, specific learning difficulties such as Dyslexia, Dyscalculia, Developmental Co-ordination Disorder (Dyspraxia) and Speech and Language difficulties, or emotional wellbeing and mental health difficulties?**

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| If there is family history, what is their relationship to the child/young person and please state if the conditions are diagnosed, suspected or self-identified. |

**Has your child/young person ever had an assessment for Neurodevelopmental difficulties (Autism Spectrum Disorder or Attention Deficit Hyperactivity Disorder)?**

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| Who completed the assessment (e.g. Private Assessment by Psychiatrist, Emotional/ Mental Health services, Neurodevelopmental Assessment Team, etc)? |
| What was the outcome of the assessment (e.g. diagnosis of ADHD was given, did not meet criteria for a diagnosis of ASD)? |

**Does the child/young person have difficulties with their emotional wellbeing and mental health?**

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| If yes, how long have these difficulties been ongoing? |
| Are there any specific triggers? |
| What is the impact of these difficulties on the child/ young person (e.g school refusal)? |
| What support have they received for this (e.g Cardiff and Vale Emotional Wellbeing and Mental Health Services/ wellbeing provision within school/ local authority Vale Families First/ Family Gateway)? |

**Has the child/young person had any significant life events or experiences which may have been overwhelming or stressful for them?**

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| If yes, what events or experiences have affected this (e.g. moving homes/houses, moving schools/other significant transitions, loss of a loved one/pet, traumatic events, fighting/arguments at home, etc.)? |
| What support have they received for this? |

**Are there any additional stressor for family and child/young person (e.g. family illness, parental separation, loss, parental mental health issues)?**

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| If yes, please elaborate: |

**Developmental History**

**You may wish to use the Red Book to fill out this section.**

Please make sure to provide **examples/details** if you tick **‘yes’** to any item(s)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **If yes, please give details:** |
| Were there any complications in the pregnancy or delivery of your child/young person (e.g. low birth weight)? |  |  |  |
| Were there any significant differences with early eating/sleeping? |  |  |  |
| Were they interactive? Did they take interest in the world around them? Did they enjoy two-way baby games  (e.g. peekaboo)? |  |  |  |
| **Did your child/young person have any differences in developing in the following areas:** | | | |
| Did they develop motor skills early, late or within range (e.g. sitting up unaided, crawling, walking)? |  |  |  |
| Did they develop speech early, late or within range? |  |  |  |
| Were there differences in their Speech (e.g. how clear they sounded, tone, pitch)? |  |  |  |
| Differences with Understanding Language? |  |  |  |
| Was there ever a time when they seemed to lose language skills? |  |  |  |
| Did your child/young person have any early differences in interaction/ friendships/ play (e.g. at nursery or playgroup)? Did nursery/ playgroup raise any concerns? |  |  |  |
| Did they enjoy parties/ school discos? |  |  |  |
| Did they have any difficulties separating from their carers when a toddler?  Please include how long this went on for and how easy/hard it was to soothe them. |  |  |  |
| **As a toddler:** | **Yes** | **No** | **If yes, please give details:** |
| Were there any difficulties with activity levels? |  |  |  |
| Did they have difficulties focusing on one toy at a time? |  |  |  |
| Did they have difficulties sitting still for things like meals? |  |  |  |
| Was it difficult to manage them when you went out with them? |  |  |  |
| **Other:** | **Yes** | **No** | **If yes, please give details:** |
| Were they impulsive (e.g. running out into the road)? |  |  |  |
| Has your child/young person had any past significant medical difficulties (e.g. hospitalisations, sight or hearing issues, injuries, tics)? |  |  |  |
| **Skills Now:** | **Yes** | **No** | **If yes, please give details:** |
| Do they appear to have co-ordination and/or balance difficulties, drop things, bump into things or have differences with personal space? |  |  |  |
| How are they with completing activities of daily living such as washing, dressing, brushing their teeth etc? |  |  |  |
| Does your child/young person have any difficulties with fine motor skills (buttons, laces, etc)? |  |  |  |
| Do they have difficulties with handwriting? |  |  |  |
| Do they have any difficulties with gross motor skills (riding a bike, kicking a ball, etc)? |  |  |  |
| How long has your child/young person been having difficulties? | | | |
| What is the impact of those difficulties on the child’s/young person’s and family’s life (e.g. school life, friendships, mood, etc)? | | | |
| What are your child’s/young person’s strengths? | | | |

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| **Have you received any of the following support?** | | | |
|  | **Yes** | **No** | **If yes, please give details:** |
| Parenting Support group |  |  |  |
| Individual parenting support |  |  |  |
| Support from Emotional Wellbeing and Mental Health |  |  |  |
| Social care / Family support |  |  |  |
| Other |  |  |  |

Please make sure to provide **examples/details** if you tick **‘yes’** to any item(s).

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of School:** | | | |
|  | **Yes** | **No** | **If yes, please give details:** |
| Has your child/young person ever needed any specialist support in school? |  |  |  |
| Have they ever attended a special school? |  |  |  |
| Does your child/young person enjoy school? |  |  |  |
| **Has the school ever expressed concerns in any of the following areas:** | | | |
| Learning? |  |  |  |
| Behaviour? |  |  |  |
| Relationships with other children? |  |  |  |

**Social Communication Skills and Interactions With Others.**

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| Please can you describe their ability to read body language, facial expressions, tone of voice, gestures and social cues? |
| Do they have any differences in use of body language and/ or facial expressions themselves? |
| Are there any differences in eye contact? Please give context. |
| Do they initiate social interactions with others? |
| What do they usually like to talk about? Are they able to engage in a back and forth conversation? |
| Do they answer questions with enough information? |
| Do they ask questions about you or others? |
| How would they react to an emotional state in others (e.g. if someone was upset)? |
| Are there any differences in speech and use of language (e.g. advanced vocabulary and formal speech)? Please also comment on tone, pitch and volume. |
| How is their understanding of sarcasm, non-literal language (e.g. its raining cats and dogs) and jokes? |
| How is their ability to communicate their thoughts and feelings? |
| Please describe any past concerns that have improved: |
| Please describe their friendships: |
| Do they have any difficulty making friends and/ or maintaining friendships? |

**How does your child/young person manage change/being flexible (e.g. routines, being changed)?**

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| How would they react to changes in plans/routines? |
| Are they able to be flexible around things such as rules and perspectives (e.g. considering the point-of-view of others)? |
| How do they manage transitions (e.g. school to home, ending play)? |
| Has anything worked well in helping them manage change? |
| What are their interests? |
| Is there anything they like doing or watching over and over? |
| Do they have anything they are intensely interested in? Or any highly specific interests? |
| Please describe their play: |
| Is there any repetitiveness to their play? |
| Do they have any routines at home that must be carried out in a certain way? |
| Do they have any repeated body movements (e.g. rocking/ spinning)? |
| Do they have any movements of their hands that you see repeated (e.g. flicking their fingers, hand flapping)? |
| Do they skin-pick, bite nails or repeatedly rub their skin? |
| Do they repeat any noises, words or phrases? |

**Attention, Concentration, Activity and Impulsivity.**

**Please describe any concerns around your child’s/young person’s attention and concentration.**

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| --- |
| When is their attention at its best? Do they Hyper-focus? |
| When is their attention at its worst? |
| How are their organisational and time-management skills? |
| Do they ever lose focus or get side-tracked when carrying out an instruction? Please give examples. |
| Are they forgetful? |

**Please describe any concerns around your child’s/young person’s activity levels.**

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| --- |
| Do they have larger signs of activity levels (e.g. constantly on the go, bouncing off walls)? |
| Do they have smaller signs of activity levels (e.g. fiddling with things constantly, fidgeting, shaking legs all the time, shifting constantly in their seat)? |
| Do their activity levels increase/decrease in certain situations? |

**Please describe any concerns around your child’s/young person’s impulsivity.**

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| --- |
| Do they act without thinking? Do they act without thinking? |
| Are they able to wait in a line/wait their turn? |
| Do they interrupt conversation, talk excessively? |
| Do they appear to lack an awareness of danger? |

**Sensory**

|  |  |  |  |
| --- | --- | --- | --- |
| Please make sure to provide **examples/details** if you tick **‘yes’** to any item(s)  **Does your child/young person have any differences in response to sensory input (e.g. seeking or aversion to)?** | | | |
|  | **Yes** | **No** | **If yes, please give details:** |
| Noise? |  |  |  |
| Light? |  |  |  |
| Taste? |  |  |  |
| Touch? |  |  |  |
| Smell? |  |  |  |
| **Do they seem to pick up on bodily sensations:** | | | |
| Needing the toilet? |  |  |  |
| Feeling hungry? |  |  |  |
| Temperature? |  |  |  |
| Pain? |  |  |  |

**Child’s/Young Person’s View**

**This section can be filled in by the child/young person or in collaboration with the parent.**

|  |
| --- |
| What do they think would help? |
| What is the child’s/young person’s view on what support or help they need? |
| What is their view on seeking a diagnostic assessment for Autism and/or ADHD? |
| How does the child/young person feel about the difficulties they are having? |

**SNAP IV – Parent Rating Scale**

Name of child/young person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by (name and relationship to child): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **For each item, select the box that best describes this child. Put only one tick per item.** | | **NOT AT ALL (0)** | **JUST A LITTLE (1)** | **QUITE A BIT (2)** | **VERY MUCH (3)** |
| 1. | Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities |  |  |  |  |
| 2. | Often has difficulty sustaining attention in tasks or play activities. |  |  |  |  |
| 3. | Often does not seem to listen when spoken to directly. |  |  |  |  |
| 4. | Often does not follow through on instructions and fails to finish schoolwork, chores, or duties. |  |  |  |  |
| 5. | Often has difficulty organising tasks and activities. |  |  |  |  |
| 6. | Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g. schoolwork or homework). |  |  |  |  |
| 7. | Often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books or tools). |  |  |  |  |
| 8. | Often is distracted by extraneous stimuli. |  |  |  |  |
| 9. | Often is forgetful in daily activities. |  |  |  |  |
| 10. | Often fidgets with hands or feet or squirms in seat. |  |  |  |  |
| 11. | Often leaves seat in classroom or in other situations in which remaining seated is expected. |  |  |  |  |
| 12. | Often runs about or climbs excessively in situations in which it is inappropriate. |  |  |  |  |
| 13. | Often has difficulty playing or engaging in leisure activities quietly. |  |  |  |  |
| 14. | Often is “on the go” or often acts as if “driven by a motor”. |  |  |  |  |
| 15. | Often talks excessively. |  |  |  |  |
| 16. | Often blurts out answers before questions have been completed. |  |  |  |  |
| 17. | Often has difficulty waiting turn. |  |  |  |  |
| 18. | Often interrupts or intrudes on others (e.g. butts into conversations/games). |  |  |  |  |
| 19. | Often loses temper. |  |  |  |  |
| 20. | Often argues with adults. |  |  |  |  |
| 21. | Often actively defies or refuses adult requests or rules. |  |  |  |  |
| 22. | Often deliberately does things that annoy other people. |  |  |  |  |
| 23. | Often blames others for his/her mistakes or misbehaviour. |  |  |  |  |
| 24. | Often touchy or easily annoyed by others. |  |  |  |  |
| 25. | Often is angry or resentful. |  |  |  |  |
| 26. | Often is spiteful or vindictive |  |  |  |  |

**Thank you for your assistance.**