Neurodevelopmental Service Referral Form A

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	

We welcome receiving correspondence in Welsh, we will respond to correspondence in Welsh, correspondence in Welsh will not lead to delay.

Rydym yn croesawu cael gohebiaeth yn Gymraeg, y byddwn yn ateb gohebiaeth yn Gymraeg, ac na fydd gohebu yn Gymraeg yn arwain at oedi.

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)

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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)

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