**South East Essex Children’s Services The Lighthouse Child Development Centre**

Please return by email to: **epunft.seechs.singlepointofaccess@nhs.net**

Telephone: **0344 257 3952**

**No handwritten forms will be accepted - only this electronic form.**

**Incomplete forms will be returned.**

**Supplementary Referral Information for Neurodevelopment (ASD & ADHD) Assessment:**

**Parents or Carers**

**If you would like help filling out this form, please start by asking your child’s school or social worker. If this is not appropriate, please contact our team to support you.**

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| By returning the completed form, **we assume that you as the parent or carer are consenting** to the referral being processed by Children’s Services. |

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| **CHILD’S DETAILS** |
| **Name:** |  |
| **DOB:** |  | **NHS Number:** |  |
| **Address:** |  |
| **GP Details:** |  |
|  **DETAILS OF PARENTS/ CARERS FILING IN THE FORM** |
| **Name:** |  |
| **Address, if different:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

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| **Please summarise your main concerns**  |
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| **Are there concerns at home/at school or in both situations?** |
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| **How old was your child when you became concerned?** |
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| **In what way do you hope this assessment will help your child?** |
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| **FAMILY HISTORY: WHO IS IN YOUR CHILD’S CLOSE FAMILY?** |
| **Name** | **Age** | **Gender** | **Relationship to the child** |
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| **Does any family member have any of the following conditions?** |
| Neurological Disease | YES |  | NO |  |
| Learning difficulties | YES |  | NO |  |
| ADHD | YES |  | NO |  |
| Autistic Spectrum Disorder | YES |  | NO |  |
| Mental Health disorder/ concerns | YES |  | NO |  |
| Other significant health issue | YES |  | NO |  |
| **If yes, please specify:** |
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| **Developmental milestones (please detail if there was any delay or history of a loss of skill):** |
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| **COMMUNICATION** |
| **Please describe any speech and language difficulty your child is experiencing now or has had in the past** |
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| **Please describe your child’s communication. Tell us who they communicate with, how they communicate, why they communicate – for example: to express their needs, to give information, to share experiences, to have a to and fro conversation, or ‘no concerns’.**  |
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| **Please describe any difficulties that your child has with listening, responsiveness, understanding what you have said or following instructions**  |
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| **Does your child have** |
| Difficulties in understanding humour or sarcasm | YES |  | NO |  |
| Repetitive speech, i.e. repeating words or phrases from other/ tv | YES |  | NO |  |
| Unusual characteristics of their communication such as using an unusual accent, or overly loud or quiet voice or speaking too fast or in an unusual way | YES |  | NO |  |
| Difficulties using non-verbal communication effectively such as a lack of facial expression, pointing, waving, or gesturing or looking awkward while communicating | YES |  | NO |  |
| Lack of, or prolonged, eye contact  | YES |  | NO |  |
| A lack of responsiveness to their name being spoken  | YES |  | NO |  |
| Talks excessively and is difficult to stop | YES |  | NO |  |
| **Comments:** |
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| **SOCIAL INTERACTION** |
| **How does your child get on with other members of the family?**  |
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| **How does your child get on with other children/young people?**  |
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| **Does your child** |  |  |  |  |
| Make and maintain friendships?  | YES |  | NO |  |
| Have any close friendships?  | YES |  | NO |  |
| Share interest and enjoyment with you or others?  | YES |  | NO |  |
| Initiate interaction with others?  | YES |  | NO |  |
| Understand the feelings of other people?  | YES |  | NO |  |
| Understand how to behave in different situations?  | YES |  | NO |  |
| Show concern for others who are hurt or upset?  | YES |  | NO |  |
| Change mood quickly and drastically | YES |  | NO |  |
| Cries easily | YES |  | NO |  |
| **Comments:** |
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| **PLAY AND IMAGINATION** |
| **What does your child like to play with or how do they spend their time?**  |
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| **Do they have unusual aspects to their play? Or did they when younger? *(Please describe)*** |
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| **Please give details of any intense or unusual interests that your child may have:**  |
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| **Please outline any routines that your child shows a strong preference for or has to follow:**  |
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| **Does your child:** |
| Engage in repetitive behaviours or rituals (doing the same thing in a certain way?)  | YES |  | NO |  |
| Have difficulty with minor changes in routine?  | YES |  | NO |  |
| **Comments:** |
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| **SENSORY PROCESSING** |
| **Response to noise:** |
| Distracted by noises easily | YES |  | NO |  |
| Distressed by noise/ covers ears | YES |  | NO |  |
| Slow to respond when you speak to them | YES |  | NO |  |
| **Response to touch:** |
| Reacts emotionally or aggressively to touch | YES |  | NO |  |
| Difficulty standing in line | YES |  | NO |  |
| Dislikes messy play OR prefers dry messy play e.g. rice, sand, pasta | YES |  | NO |  |
| **Response to movement:** |
| Often fidgets/bounces jumps/flaps hands and seems to get joy from this | YES |  | NO |  |
| Often bumps into things, leans against surfaces, slouches and may not realise they are doing it | YES |  | NO |  |
| Cautious with movements – dislikes swings/slides | YES |  | NO |  |
| Difficulty climbing stairs | YES |  | NO |  |
| **Response to taste/smell:** |
| Eats a small range of foods that are similar in taste and texture e.g. bland and crunchy | YES |  | NO |  |
| Avoids certain tastes/ textures/ smells of food | YES |  | NO |  |
| Prefers foods with bold flavours and textures; has more of an adult pallet  | YES |  | NO |  |
| **Response to Light:** |
| Enjoys watching things move, can become fixated on lights,  | YES |  | NO |  |
| Avoids bright lights OR can become very distressed in bright light | YES |  | NO |  |
| **Other behaviours:** |
| Runs up and down repetitively | YES |  | NO |  |
| Walks on tiptoes | YES |  | NO |  |
| Makes or blurts out loud noises or hums | YES |  | NO |  |
| Interested in the texture of materials and toys | YES |  | NO |  |
| Body-focussed repetitive rubbing/ picking skin/ pulling hair  | YES |  | NO |  |

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| **MOTOR MANNERISMS (Stimming or repetitive body movements)**  |
| **Does your child…**  |
| Often walk on their tiptoes or walk in an unusual way | YES |  | NO |  |
| Like to spin themselves around more than other children  | YES |  | NO |  |
| Flap their hands or bounce on their feet when excited  | YES |  | NO |  |
| Rock themselves  | YES |  | NO |  |
| **ATTENTION AND ACTIVITY LEVELS** |
| **Please outline any repetitive/unusual body movements that your child engages in:**  |
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|  | **Never** | **Sometimes** | **Always** |
| Blurts answers/ doesn’t wait for question to be asked  |  |  |  |
| Is overbearing and loud while playing with peers |  |  |  |
| Takes actions without thinking of the consequences  |  |  |  |
| Acts then instantly says they didn’t mean to  |  |  |  |
| Difficulty staying on task in the class or in play |  |  |  |
| Disturbs others when playing or working  |  |  |  |
| Has ‘careless mistakes’ or inaccuracies in work |  |  |  |
| Gets out of their seat when not expected  |  |  |  |
| Climbs and jumps when being still is expected |  |  |  |
| Fidgets and squirms  |  |  |  |
| Is always ‘on the go’ |  |  |  |
| Difficulty listening to teaching part of lesson/ assembly |  |  |  |
| Avoids or dislikes activities which require mental effort |  |  |  |
| Doesn’t finish tasks |  |  |  |
| Finds it difficult to start tasks (even ones they could easily do) |  |  |  |
| Is forgetful during tasks |  |  |  |
| Often loses items  |  |  |  |
| Cannot get organised with equipment needed |  |  |  |

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| **BIRTH DETAILS** |
| **Did you/ your child’s mother have any health concerns, during pregnancy?** |
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| **Did you/ your child’s mother take any medication during pregnancy? (If so, what did you take?)**  |
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| **How long was the pregnancy in weeks (full-term is 37 to 40 weeks).**  |
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| **What was your child’s birth weight?** |
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| **Is there any history of post-natal depression?** |
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| **How was your child delivered and did they require any aftercare following birth? *(Please tick)***  |
| Normal |  | C-Section |  | Ventouse/Forceps |  |
| **Comments:** |
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| **At or after delivery**  |
| Resuscitation needed  | YES |  | NO |  |
| Admitted to special care  | YES |  | NO |  |
| Feeding difficulties  | YES |  | NO |  |
| Postnatal depression  | YES |  | NO |  |
| **Comments:** |
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| **EARLY DEVELOPMENT** |
| **Were any of the following areas of your child’s development of concern to you after birth**  |
| Gross motor skills – sitting, walking or running  | YES |  | NO |  |
| Any regression of gross motor skills  | YES |  | NO |  |
| Fine motor skills – picking up and handling toys or cutlery, drawing or cutting  | YES |  | NO |  |
| Language - What age did they speak words other than mama and dad?  | YES |  | NO |  |
| Any speech regression  | YES |  | NO |  |
| Hearing  | YES |  | NO |  |
| Eyesight  | YES |  | NO |  |
| Self-help skills – dressing, feeding, toileting  | YES |  | NO |  |
| Play skills  | YES |  | NO |  |
| imaginative or pretend play skills – copying household activities, dressing up or playing with dolls or teddies or small world play | YES |  | NO |  |
| Aggressive or irritable behaviour  | YES |  | NO |  |
| Loss of any skills that they previously had  | YES |  | NO |  |
| **Please outline any concerns about early development here:** |
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| **EDUCATION** |
| **Name of the preschool/nursery or school attended. Please write home schooled stating the reasons why the child is/was home schooled (if applicable).**  |
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| **Please describe difficulties the child experienced during their preschool, nursery or primary or secondary school years as applicable? (Bullying, running away from school, social isolation, poor school attendance, exclusions etc.)**  |
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| **Please describe any extra support the child received at preschool nursery, primary or secondary school:** |
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| **MENTAL AND EMOTIONAL WELLBEING** |
| **Please tick against any concerns you have about your child’s emotional well-being:** |
|  | Anxiety  |  | Fears or phobias  |  | Obsessive Compulsive Behaviours  |
|  | Hyperactivity  |  | Hallucinations  |  | School attendance issues |
|  | Mood Swings  |  | Eating Disorder  |  | Anger or aggression  |
|  | Low Mood  |  | Suicidal Ideation  |  | Domestic Violence  |
|  | Bereavement  |  | Self-Harm  |  | Drug or Alcohol use or addiction  |
|  | Impulsivity  |  | Short Attention span  |  | Criminal activity/ antisocial behaviours and/or Involvement with Youth Offending Team |
| **Has your child ever had treatment (including hospitalisation) by, or is currently seeing, a psychiatrist, psychologist, therapist, or counsellor?**  | YES |  | NO |  |
| **If yes, please give the following details: Nature of the concerns; start and end date of support; where seen and clinician’s name; type of support, for example: counselling, play therapy, cognitive behaviour therapy, group work, family work, parent support and advice.**  |
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| **PREVIOUS ASSESSMENTS** |
| **Please indicate if your child has had any of the following assessments? Please attach copies of any reports and information on support provided**  |
|  | Paediatric developmental assessment  |  | Educational psychological assessment  |
|  | Clinical psychological assessment  |  | Speech and language assessment |
|  | CAMHS assessment  |  | Occupational Therapy assessment  |
|  | Children’s Centre  |  | Special Needs Health visitor  |
|  | Health visitor  |  | Early Years SEN team or Communication and Autism Team (advisory teachers)  |
|  | SEN Specialist Advice and Support Service  |  | School support including SENCO, TAC (Team Around the Child), parent support, counselling, circle of friends, social support, behaviour support, Pupil Support Base  |
|  | Social Services including CIN (Child in Need) and CP (Child Protection)  |  | CAMHS Step 2 and Specialist CAMHS  |
|  | Families First/ Intensive Family Support  |  | Angels/Add-vance/Space/other voluntary agency |
|  | Other - Please specify (including in the NHS, Independent or charity sector): |
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| **INFORMATION SHARING AND CONSENT:** |
| **Information about your child may be shared with other teams and agencies (eg Education services, Children’s Centres and social care) in order to identify the most appropriate support for your child** |
| Has the referral been discussed with the child or young person?  |  YES |  | NO |  |
| Is there parental consent for enquiry/onward referral to other agencies?  |  YES |  | NO |  |
| Is there parental consent to contact school?  |  YES |  | NO |  |
| Is there child consent to be contacted whilst at school?  |  YES |  | NO |  |

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| **Signed (Parent/Carer):**  |  | **Date:** |  |

**THANK YOU FOR COMPLETING THIS FORM**