



Autism Service Referral form

If you suspect you or an adult you are supporting might have Autism or has already a diagnosis of Autism and wants to receive support, please use this referral form to access the Barnet Autism Service delivered by Barnet Mencap.

The Service is the first step to a diagnosis. The patient will receive Autism Screening. The screening takes into account factors to investigate whether adults of average intelligence have symptoms of Autism. The Screening will indicate those patients who do not demonstrate Autistic symptoms and highlight those patients who do. The results and actions taken will be fed back to the GP. The GP will be able to make a more informed referral for a formal diagnosis, cutting down on unnecessary expensive referrals and offering patients services and support in their own borough without a waiting list.

Client Personal Information Please complete this section with Clients contact details

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | | | **Surname** |  | | |
| **Address:** |  | | | | | | |
|  | | | | | **Postcode** |  | |
| **Telephone number** | |  | | | | | |
| **Mobile number** | |  | | | | | |
| **Email address** | |  | | | | | |
| **Date of birth** | |  | **Do you have a diagnosis of Autism** | | | | **Yes**  **No** |

|  |  |  |
| --- | --- | --- |
| Ethnicity (please tick) | | |
| White British | Mixed other | Black or Black British African |
| White Irish | Asian or Asian British Indian | Black or Black British Other |
| White Other | Asian or Asian British Pakistani | Chinese |
| Mixed white & Black Caribbean | Asian or Asian Bangladeshi | Mixed white & Asian |
| Mixed white & Black African | Asian or Asian British other | Black or black British Caribbean |
| Prefer not to disclose |  |  |
| Other Ethnic Group (please state) | | |
| I identify my Gender as: Male  Female  Transgender, non binary | | |

|  |  |
| --- | --- |
| GP Practice name |  |
| GP name |  |
| Telephone number |  |
| Email |  |

Client’s GP Practice

Referral Organisation details (if different from GP)

|  |  |  |  |
| --- | --- | --- | --- |
| Organisation name |  | Date |  |
| Contact name |  | | |
| Telephone number |  | | |
| Email |  | | |
| Referral request | Autism Screening  Autism Services | | |
| Any risks we need to be aware of? |  | | |
| **Any additional support needs?** |  | | |

**Reason for referral:**

## 

## Preferred method of communication? (Please tick)

Telephone  Email  Text  Letter

## Data protection

The Autism Service, delivered by Barnet Mencap on behalf of Barnet CCG is compliant with the Data Protection Act 1998. The Autism Service and Barnet Mencap follow strict confidentiality rules and guidelines in line with the law and organisations procedure. All information about you will be stored and transferred in a safe and secure manner as required by the Data Protection Act 1998.

The information contained in this form will be used by Barnet Mencap for the purposes of finding the right support or opportunity and will form part of a client file which will be stored safely. Barnet Mencap will ask for your permission to share the information with other organisations.

No illegal drugs or alcohol are allowed on the premises. You will be asked to leave if you are intoxicated or carry either of these substances or if your behaviour is deemed aggressive or inappropriate.

Barnet Mencap staff will not tolerate rude or abusive behaviour.

**Return Form to:**

**Barnet Mencap, Autism Service**

35 Hendon Lane Finchley London

N3 1RT

**Email**: projectsupport@barnetmencap.org.uk

T: 020 8349 3842