NHS Template

Children & Young People Right to Choose Referral Form

January 2025

# Under 18's Right to Choose

This form should only be completed and signed by GP. For this service, please email this referral form (along with any other supporting documentation) to: **[kmicb.psicon.childrens@nhs.net](mailto:kmicb.psicon.childrens@nhs.net)**

## Autism spectrum disorder (ASD) assessment pathway:

Psicon accept new referrals for Children and Young People (CYP) **aged 3y 0m – 17y** 364 days for autism spectrum disorder (ASD). Once Psicon receive the referral, parent/guardian will be invited to carry out the screening process to determine whether the CYP meets the threshold for a full assessment. Assessments for autism are currently only offered face-to-face at our clinic in Canterbury, Kent or Basingstoke, Hampshire.

## Attention Deficit Hyperactivity Disorder (ADHD) assessment pathway:

Psicon accept new referrals for CYP **aged 6y 0m – 17y** 364 days for ADHD. Once Psicon receive the referral, parent/guardian will be invited to carry out the screening process to determine whether the CYP meets the threshold for a full assessment. Assessments for ADHD can be either face-to-face at our clinic in Canterbury, Kent or Basingstoke, or online. Online assessments are not suitable for all children, and we can only carry these out for those who are deemed to be clinically suitable. A decision on whether an individual child is suitable to be seen online is made on a case-by-case basis once the referral has been reviewed.

**Exclusion Criteria** for the service:

* CYP who present with co-morbid mental health difficulties and/or risk to self/others.
* CYP with a moderate to severe learning disability.

Psicon handle personal information in accordance with the Data Protection Act 2018 and the General Data Protection Regulations 2018. We will process personal information in ways that respects individual rights and in line with our company values, exercising the highest standards of confidentiality, integrity, and trust. For more information, please see the P[rivacy Notice](https://www.psicon.co.uk/legal/privacy-policy). You can also request a copy from one of our reception areas or by emailing [righttochoose@psicon.co.uk](mailto:righttochoose@psicon.co.uk)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Child/Young Person’s Details | | | | | | | | | | |
| **Name:** | |  | | | | | | | | |
| **NHS number:** | |  | | | | | | | | |
| **Date of birth:** | |  | | | | | | | | |
| **Gender:** | |  | | | | | | | | |
| **Ethnicity:** | |  | | | | | | | | |
| **Full address:** | |  | | | | | | | | |
| **School name and address:** | |  | | | | | | | | |
| **Is the child or young person:**  (Please tick all that apply) | | **Looked after child (by local authority)** | | | | | | |  | |
| **Under a special guardianship order** | | | | | | |  | |
| **Adopted** | | | | | | |  | |
| **Not in education / home-schooled** | | | | | | |  | |
| **Military family** | | | | | | |  | |
| **Social worker details:**  (If applicable) | | **Full name:** | |  | | | | | | |
| **Team:** | |  | | | | | | |
| **Contact details:** | |  | | | | | | |
| 1. Assessment / Referral Request | | | | | | | | | | |
| **Please select the referral request:** | | | | | | | | | | |
| **Autism spectrum disorder (ASD) assessment** | | | | | | | |  | | |
| **Attention Deficit Hyperactivity Disorder (ADHD) assessment** | | | | | | | |  | | |
| **Dual – ASD & ADHD assessment** | | | | | | | |  | | |
| 1. Parent / Guardian Details | | | | | | | | | | |
| **Full name:** | | | |  | | | | | | |
| **Relationship to the child/young person:** | | | |  | | | | | | |
| **Full address:**  **(If different from the child/young persons)** | | | |  | | | | | | |
| **Mobile number:** | | | |  | | | | | | |
| **Home number:** | | | |  | | | | | | |
| **Email address:** | | | |  | | | | | | |
| **Please list names of all parties with parental responsibility and their relationship to the child / young person:** | | | |  | | | | | | |
| 1. GP Referrer Details | | | | | | | | | | |
| **GP name:** | | | |  | | | | | | |
| **GMC number:** | | | |  | | | | | | |
| **GP address:** | | | |  | | | | | | |
| **GP telephone number:** | | | |  | | | | | | |
| **GP email address:** | | | |  | | | | | | |
| 1. Background information | | | | | | | | | | |
| 1. **Language and conversation** | | | | | | | | | | |
| **Uses full sentences correctly** | | | | | | | | |  | |
| **Speaks in simple phrases (e.g., a 3-word sentence that is not repeating what you have already said)** | | | | | | | | |  | |
| **Speaks in single words** | | | | | | | | |  | |
| **Does not communicate verbally/selectively mute** | | | | | | | | |  | |
| 1. **Does the child/young person report having any sensory sensitivities?** | | | | | | | | | | |
| **None reported** | | | | | | | | |  | |
| **Smell** | | | | | | | | |  | |
| **Taste** | | | | | | | | |  | |
| **Light** | | | | | | | | |  | |
| **Textures** | | | | | | | | |  | |
| **Sounds** | | | | | | | | |  | |
| **If yes to any of the above, please detail further below:** | | | | | | | | | | |
|  | | | | | | | | | | |
| In addition to yourself (the GP), has any other professional ever suggested the patient might have ASD/ADHD? | | | | **Yes** | |  | **No** | | |  |
| 1. **Does the child/young person show significant signs of the following?** (Please select all that apply) | | | | | | | | | | |
| Difficulties with forming and/or maintaining friendships with their peers. | | | | | | | | |  | |
| Difficulties with verbal communication. | | | | | | | | |  | |
| Difficulties with non-verbal communication (e.g., eye contact, appropriate facial expressions). | | | | | | | | |  | |
| Difficulties regulating their emotions to a greater extent than other children their age. | | | | | | | | |  | |
| Intense interests which are unusual in content and/or scope. | | | | | | | | |  | |
| Repetitive behaviours (e.g., “stimming”) incl. echolalia. | | | | | | | | |  | |
| Difficulties with hyperactivity. | | | | | | | | |  | |
| Difficulties responding to instructions. | | | | | | | | |  | |
| Difficulties with organisation. | | | | | | | | |  | |
| Concerns with academic progress. | | | | | | | | |  | |
| 1. **How do these difficulties present in the following environments:** | | | | | | | | | | |
| **At home:** |  | | | | | | | | | |
| **At school/nursery:** |  | | | | | | | | | |
| 1. **What has led to the CYP/Parent/Guardian seeking a referral for a diagnostic assessment now?** | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. **In what way does the CYP/Parent/Guardian hope to benefit from an assessment?** | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. Risk | | | | | | | | | | |
| **Has the child/young person:** | | | ****Recent/Ongoing****  ****(within the past 6 months)**** | | | ****Historic****  ****(6+ months ago)**** | | | | ****Never**** |
| **Self-harmed to a degree that has required treatment by a healthcare professional (e.g., stitches)?** | | |  | | |  | | | |  |
| **Self-harmed by head banging, hair pulling, scratching, superficial cutting, or other ways that have not required medical attention?** | | |  | | |  | | | |  |
| **Made an attempt to end their life?** | | |  | | |  | | | |  |
| **Expressed thoughts about ending their life or that they would be better off dead?** | | |  | | |  | | | |  |
| **Engaged in risky behaviour, e.g., use of drink and drugs, theft, or other criminal behaviour?** | | |  | | |  | | | |  |
| **Harmed another person to the extent that person has required treatment by a healthcare professional?** | | |  | | |  | | | |  |
| Psicon are a diagnostic only service, and we are not commissioned to provide mental health support. We are therefore unable to accept referrals where a CYP is at risk to themselves, to others or from others.  If you ticked “Recent/ongoing” for any of the above, we will be unable to accept the referral. Please refer to your local mental health service. | | | | | | | | | | |
| **If you selected “Historic” for any of the above, please provide details (including whether support was received at the time or if any services were involved/informed)** | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. Supporting Information | | | | | | | | | | |
| **Please tick if the child/young person has any of the following:** | | | | | | | | | | |
| MILD learning disability | | | | |  | | | | | |
| MODERATE-SEVERE learning disability | | | | |  | | | | | |
| Suspected UNDIAGNOSED learning disability | | | | |  | | | | | |
| Diagnosed ASD | | | | |  | | | | | |
| Diagnosed ADHD | | | | |  | | | | | |
| Dyslexia | | | | |  | | | | | |
| Dyspraxia | | | | |  | | | | | |
| **Please describe any diagnoses and/or current concerns regarding the CYP’s mental health: (or leave blank if included in the summary care record)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Please list any diagnoses and/or current concerns regarding the CYP’s physical health:**  **(or leave blank if included in the summary care record)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Please list any medication prescribed for the CYP (medication name and dose):**  **(or leave blank if included in the summary care record)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **If applicable, please enter the name of any paediatrician, speech & language therapist, or other healthcare professional/service (including CAMHS/mental health team) that the child is being, or has been seen by:** | | | | | | | | | | |
| Name of professional/service: | | | |  | | | | | | |
| Role/reason for input: | | | |  | | | | | | |
| Date seen from and to: | | | |  | | | | | | |
| **If applicable, please detail any relevant information not requested above:** | | | |  | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Additional Needs | | | | | | | | | |
|  | | | **Child/Young Person** | | | | **Parent/Guardian** | | |
| **Yes** | | **No** | | **Yes** | | **No** |
| British sign language interpreter | | |  | |  | |  | |  |
| Step free access/ground floor consulting room | | |  | |  | |  | |  |
| Interpreter required | | |  | |  | |  | |  |
| Hearing impairment | | |  | |  | |  | |  |
| Visual impairment | | |  | |  | |  | |  |
| If yes to any of the above, please give further information: | | |  | | | | | | |
| 1. Consent | | | | | | | | | |
| The CYP/parent/guardian has given consent for the information provided within this referral to be sent to the care provide and for the summary care record to be accessed for the duration of their treatment. | | **Yes** | |  | | **No** | |  | |
| 1. Attachments | | | | | | | | | |
| Please attach the patients’ medical summary/summary care record.  If applicable, please attach any relevant clinical correspondence and reports such as:   * current/past assessment reports (Neurodevelopmental, OT, SLT, etc). * copies of reports from previous involvement with CAMHS. | | | | | | | | | |
| 1. Signature of Professional | | | | | | | | | |
| Referrer signature: |  | | | | | | | | |
| Referrer name: |  | | | | | | | | |
| Date of signature: |  | | | | | | | | |

**Please note that we are unable to backdate referrals. Referrals will be processed by the date this form is received to kmicb.psicon.childrens@nhs.net**