NHS Template

Adult Right to Choose
Referral Form

June 2025

# Adult 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.adults@nhs.net

**Autism spectrum disorder (ASD) assessment pathway:**

**Eligibility**: For adults aged 18yrs and over.

**Assessment Options**:

* Face-to-face assessments available in Canterbury (Kent).
* Online assessments (when clinically appropriate).

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

**Eligibility**: For adults aged 18yrs and over.

**Assessment Options**:

* Face-to-face assessments available in Canterbury (Kent).
* Online assessments (when clinically appropriate).

**Additional Information for ADHD Pathway:**

* Psicon can provide ADHD medication following a diagnosis of ADHD where clinically appropriate.
* If medication is initiated through Psicon:
* Once titrated and stable, shared care with the patient's GP will be requested.
* If shared care is not possible, ongoing reviews and prescriptions must continue with Psicon.
* We advise GPs to consider their ability to take on a shared care arrangement with Psicon before initiating the referral and discussing this with their patient.

**Referral Options:**

* You can refer for an autism assessment, ADHD assessment or both.

**Referral Exclusions:**

We are unable to accept referrals for patients who:

* Have co-morbid mental health or severe learning difficulties that significantly impair functioning and are likely to prevent a valid assessment from being conducted (e.g., inability to understand task instructions or hold conversations with the assessor).
* Pose a risk to themselves or others.

If there is any uncertainty about the exclusion criteria, we strongly recommend discussing this with the

patient beforehand to avoid potential disappointment should we later determine that our assessment

is not appropriate for the individual.

**Referral Form Guidance:**

* Please ensure you have the client's personal email address to facilitate contact regarding the referral.

**Contact Us:**

For any questions or further clarification, please do not hesitate to reach out. Thank you for your understanding and cooperation.

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 enquiries@psicon.co.uk

|  |
| --- |
| 1. Patient’s Details
 |
| **Name:** |  |
| **NHS number:** |  |
| **Date of birth:** |  |
| **Gender:** |  |
| **Ethnicity:** |  |
| **Full address:****Email address:****Contact number:** |  |
| **Do any of the following apply to the patient?**(Please tick all that apply) | **Allocated social worker** |  |
| **Member of the Armed Forces** |  |
| **Under a mental health team/service** |  |
| **Provide further details:** |
|  |
| **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. Mental Health Service details (if applicable)
 |
| **Name of Service:** |  |
| **Named Professional:** |  |
| **Service address:** |  |
| **Contact number:** |  |
| **Email address:** |  |
| **Please provide details of the service involvement including last known appointment:** |  |
| 1. GP Referrer Details
 |
| **GP name:** |  |
| **GMC number:** |  |
| **GP address:** |  |
| **GP telephone number:** |  |
| **GP email address:** |  |
| 1. Background information
 |
| **Do any of the following apply to the patient?** |
| **The patient is currently in prison** |  |
| **The patient is currently under investigation by the police or awaiting trial** |  |
| **Under a mental health team/service** |  |
| **None apply** |  |
| **Please tick if the client has a diagnosis of any of the following:** |
| **Psychosis/Schizophrenia**  |  |
| **Bipolar Disorder** |  |
| **Borderline/Emotional unstable personality disorder** |  |
| **Other personality disorder** |  |
| **Post Traumatic Stress Disorder (including complex PTSD)** |  |
| **Obsessive Compulsive Disorder** |  |
| **Substance misuse disorder (alcohol or drug addiction)** |  |
| **Eating Disorder** |  |
| **Depression** |  |
| **Anxiety** |  |
| **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** |  |
| **If yes, please detail further below:** |
| 1. Risk:
 |
| **Has the patient:** | ****Recent/Ongoing********(within the past 6 months)**** | ****Historic********(6+ months ago)**** | ****Never**** |
| **Attended hospital or required treatment from a medical professional as a result of intentional self-injury?** |  |  |  |
| **Self-harmed to a degree that did not require medical intervention?** |  |  |  |
| **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?** |  |  |  |
| As a neurodevelopmental diagnostic service, Psicon are not commissioned to provide mental health or crisis support. We are therefore unable to accept referrals where a patient is at risk to themselves, to others or from others. We are unable to accept referrals for patients with mental health concerns causing significant functional impairment without accompanying evidence. This evidence should discuss those concerns in detail, for example, CMHT/psychiatric/psychological assessment/discharge reports. This is to minimise the risk of diagnostic overshadowing. |
| **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 patient has any of the following:** |
| MILD learning disability |  |
| MODERATE-SEVERE learning disability |  |
| Suspected UNDIAGNOSED learning disability |  |
| Diagnosed ASD |  |
| Diagnosed ADHD |  |
| **If you have ticked diagnosed ASD or diagnosed ADHD and are referring for one or both of the same condition, please explain why you are seeking an additional assessment for your patient:** |
|  |
| **Please list any diagnoses and/or current concerns regarding the patient’s physical health:****(or leave blank if included in the summary care record)** |
|  |
| **Please list any medication prescribed for the patient (medication name and dose):****(or leave blank if included in an attached summary care record)** |
|  |
| 1. Additional Needs
 |
|  |  |
| **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 patient has given consent for the information provided within this referral to be sent to the care provider 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 CMHT.
 |
| 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.adults@nhs.net**