# **Referral Form**

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| **Referral To** |
| **Date of Referral:** | Click or tap to enter a date. |
| **Name of clinician:** | Click or tap here to enter text.  |
| **Professional specialty** | Click or tap here to enter text. |
| **Contact Details:** | Address: Click here to enter text.  |
|  | Telephone: Click here to enter text. |
|  | Email: Click here to enter text. |

Dear <Professional recipient of referral>,

Thank you for seeing <Individual’s name> for an opinion regarding their Click or tap here to enter text., and possible assessment for autism spectrum disorder (ASD).

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| **Identifying Information** |
| **Name:** | Click here to enter text. |
| **Date of Birth:** | Click or tap to enter a date. |
| **Gender** | Choose an item. |
| **Parent(s)/Caregiver(s):** | Click here to enter text. (Choose an item.) and Click here to enter text. (Choose an item.) [Delete content / row if not required] |
| **Contact Details:** | Address: Click here to enter text.  |
|  | Home Telephone: Click here to enter text. |
|  | Mobile: Click here to enter text. |
|  | Email: Click here to enter text. |
| **Age at Referral:** | Enter number year(s), Enter number month(s), Enter number day(s) |

**Reason / Rationale for referral:** Click or tap here to enter text.

**ASD signs and symptoms *reported*:** Click or tap here to enter text.

**ASD signs and symptoms *observed*:** Click or tap here to enter text.

The following standardised tool(s) were administered as part of the referral process:

**Tool:** Click or tap here to enter text.

**Results:** Click or tap here to enter text.

OR

No standardised tool(s) were administered as part of the referral process. [Delete content / row if not required]

<INDIVIDUAL’S NAME> has an existing diagnosis of Click or tap here to enter text. [Delete content / row if not required]

<INDIVIDUAL’S NAME> has had previous investigations relating to Click or tap here to enter text. with the outcome of Click or tap here to enter text.[Delete content / row if not required]

The rationale for this referral has been discussed with the individual / caregiver and they have indicated a willingness to proceed with the referral.

There Choose an item. barriers present in the individual / caregiver ability to attended clinic appointments.

 **Barrier(s):** Click or tap here to enter text.[Delete content / row if not required]

The following existing reports are available/provided from the individual and/or caregiver:

* Click or tap here to enter text.
* Click or tap here to enter text.
* [Delete content / row if not required]

In the interim, to address <INDIVIDUAL’S NAME>’s urgent support needs, the individual / family will Choose an item. support from Click or tap here to enter text.

Yours sincerely,

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| **Referral From** |
| **Referrer Name:** | Click here to enter text. |
| **Professional specialty:** | Choose an item. |
| **Contact Details:** | Address: Click here to enter text.  |
|  | Telephone: Click here to enter text. |
|  | Email: Click here to enter text. |
| **Provider number** | [Insert any Medicare/Private provider number] |