**Community Autism Support and Advice Service (CASA)**

 **Professionals Referral Form**

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| **Do they have a diagnosis of Autism?**(if answered NO and the primary presenting need is mental health, please use the CALMHS referral form) | **Yes** |  | **No** |  |
| **Where and when (approx.) were they assessed?**  |
| **Do they have a diagnosis of a Learning Disability?** | **Yes** |  | **No** |  |
| **Do they have any other diagnoses? E.g. mental health, developmental conditions and current physical conditions** |

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| **Date of referral:** |  |

|  |  |
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| **Client Name:** |  |
| **Date of Birth:**  |  |
| **NHS Number:** *(Mandatory)**(you can find this on a prescription from their GP)* |  |
| **Address:** |  |
| **E-Mail:**  |  |
| **Contact Telephone Number:** |  |
| **Preferred method of contact:** |  |
| **Communication challenges we need to be aware of:** |  |

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| **G.P. Name:** |  |
| **Surgery:** |  |
| **Address:** |  |
| **Contact Telephone Number:**  |  |

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| **Referrers Name:** |  |
| **Team:** |  |
| **Address:** |  |
| **Contact Telephone Number:** |  |
| **Contact E-Mail:** |  |

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| **Background information-** *Past involvement with Independence Trust, support & networks. Is there anything that may impact your engagement with the CASA service.*  |
| **Current outline of support being provided by your service. Work/Goals completed.**  |
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| **How Long will you continue to work with the Client?** (please indicate with X) |
| 4 weeks | 8 weeks  | 12 weeks  | 12 weeks + |
| Any additional comments including other services involved in support. |

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| **Is there any current evidence of violence/anger? Please outline risk plan if appropriate.** |
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| **Are you including a copy of the Risk Assessment?** *(please indicate with X)* |
| Yes [ ]  | No [ ]  |
| **If no, why not?** |

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| **Reason for Referral:** *How would they like to use the service? Please explain..* |
| 1:1 |  |
| Peer Support\* |  |
| Community Groups |  |
| Adult Education  |  |
| Voluntary/Paid Work  |  |
| Sensory Support  |  |
| Reasonable Adjustments  |  |
| Other  |  |

\*Please note individuals can access the online activities and drop ins without a referral

**The Service User has agreed to information sharing including risk and crisis plan?**

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| **Yes** |  [ ]  If ‘Yes’ please attach consent. |

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| **No** |  [ ]  If ‘No’, please call us to discuss how to proceed. |

**We the Referrer agree to update any relevant risk information and significant changes in support, including informing Independence Trust when we discharge from our service.**

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| **Signature of referrer:**  |  |
| **Please print name:**  |  |

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| I understand why I have been referred for support from the CASA service and feel ready to engage- | Signature or verbal consent from Individual named on this form- |
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| **Please forward your completed referral to:**  |
| *Referral & Outcome Officer**Independence Trust, Community House, 15 College Green, Gloucester, GL1 2LZ* |
| **Or by email to:** |
| *info@independencetrust.co.uk* |