**REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name:** |  | **Surname:**  |  |
| **Date of Birth:** |  | **Gender:** |  |
| **Address:** |  | Please tick which is your preferred method of contact |
|  |
| **Mobile Tel No:** |  |  |
| **Landline Tel No :** |  |  |
| **Email Address:** |  |  |
| **GP & Address:**  |  |
| **NHS No if known**  |  |
| **Confidentiality Statement** | *In order to provide you with an effective service Telford Autism Hub and our partners Midlands Partnership Foundations Trust will request information which is personal and sensitive. (Personal and Sensitive information is what you have told us about yourself, or what other organisations have told us about you, or may tell us in the future). We will store the information provided responsibly and securely in accordance with the law. We will keep a record about you and will need to share with other organisations usually MPFT and others, like GP, NHS, Local authority and community and voluntary services in order to provide services right for you. To ensure we meet our legal requirement we will share information where necessary to protect individuals from harm or injury. You have the right to see any personal information held about you. You will not be able to see information that others have given in confidence.*  |
| **Please sign if you consent to store information and understand the confidentiality statement above** |  |
| **Ethnic Origin:** | White British |  | Asian or Asian Bangladeshi |  |
| White Irish |  | Asian or Asian Any Other Background |  |
| White Any Other Background |  | Black or Black British |  |
| White & Black Caribbean |  | Black or Black Caribbean |  |
| White & Black African |  | Black or Black African |  |
| White & Asian |  | Black or Black Any Other |  |
| Mixed any Other mixed background |  | Chinese |  |
| Asian or Asian British |  | Other Ethnic group |  |
| Asian or Asian Indian |  | Not Stated |  |
| Asian or Asian Pakistani |  | Not Known |  |

**Have you had a diagnosis of Autism ?**

|  |  |
| --- | --- |
| Yes  | No |

**Reason For referral (tick which applies)**

|  |  |
| --- | --- |
| **Autism Related Support**  |  |
| **TAH Social events**  |  |

Preferred Method of Contact (please tick which applies)

|  |  |
| --- | --- |
| **Phone** |  |
| **Email** |  |
| **Letter**  |  |

|  |  |
| --- | --- |
|  |  |

If you need help completing this form please contact **01952 916109**

|  |  |
| --- | --- |
| **When completed send the referral form to us by:** | **Email:** **asd.telford@nhs.net** |
| **Post: Telford Autism Hub, Telford & Wrekin CVS , Suites 12 & 15 Hazledine House, Central Square, Telford Centre , Telford TF3 4JL** |

**Office use only**:

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Received:** | **……………………….** | **Checked on Rio** | **Yes / No** |
| **ID NO** | **……………………….** | **Risk assessment required** | **Yes / No** |