

Neurodevelopmental Specialist Service (NeSS)

REFERRAL FORM (Revised January 2024)

Please check our referral criteria below to ensure your referral is appropriate for our service as this will avoid unnecessary waiting times for the client. Please see our 'Referral Criteria and Guidance' document for further detail.

Acceptance criteria

- ✓ Adults (aged 18+)
- ✓ Nottingham city or Nottinghamshire County resident
- ✓ ASD/ADHD- seeking assessment
- ✓ Short-term and specific post diagnostic support that cannot be sought by another service
- ✓ Adults with an ADHD diagnosis requiring ADHD medication treatment initiation or review

Exclusion criteria

- ☒ Aged below 18 years
- ☒ Not a Nottingham or Nottinghamshire resident
- ☒ Clients diagnosed/suspected to have Intellectual Disability - **refer to Intellectual Disability Service**
- ☒ Referrals solely for ongoing mental health support - **refer to the Locality Mental Health Team**
- ☒ Clients currently experiencing severe mental illness (consultation to professionals may be provided)
- ☒ Support for housing/placements/social care - **refer to Adult Social Care**
- ☒ No consent from client for the referral
- ☒ Referral form and questionnaires incomplete/lacking sufficient information

NeSS Section A: To be completed by referrer (pages 1-3)

Client name:	Date of birth:	Gender identity/pronouns:
Mrs Bernadette Brandon	23 Jan 1991	Female
NHS/ Rio No.:		Email address:
424 726 9062		bernie_91@hotmail.co.uk
Address:		Contact number:
33 Russell Crescent Nottingham NG8 2BQ		07982 692795
Person making the referral:		Date of referral:
Name: Dr Salman Hussain Position: Contact details:		
Client consent: (Tick as appropriate)		
Has the client consented to the referral? <i>N.B. We cannot process a referral without the consent of the client</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the client consent to the service leaving a	Yes <input type="checkbox"/>	No <input type="checkbox"/>

voicemail?		
Does the client consent to contact via email?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

GP name and address:
Dr Salman Hussain Derby Road Health Centre Derby Road Health Centre 336 Derby Road Nottingham NG7 2DW
Existing neurodevelopmental, psychiatric or physical health diagnoses <ul style="list-style-type: none"> Please note any relevant history or formal diagnosis, given by whom, and date of any diagnosis Please provide copies of any diagnostic reports available Does the person have an Intellectual Disability, or any other registered disabilities? NB. If ID identified or suspected, please refer to ID services.
Current medication:

Referral reason: (Tick as appropriate)			
Autism diagnostic assessment	ADHD diagnostic assessment	Neurodevelopmental specific support	ADHD medication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Complete pages 1-3 only

Reason for referral If referring for diagnostic assessment, please summarise: <ul style="list-style-type: none"> The main reasons the client feels they may have autism and/or ADHD Any additional issues we may need to take into consideration Where possible, give your clinical impression regarding possible autism and/or ADHD
If the client already has a diagnosis and is being referred for neurodevelopmental support, please explain what support is being requested. <i>NB. We do not accept referrals for ongoing support and do not provide support to manage daily living. We also do not accept referrals solely for completing PIP forms. In these cases, please consider a referral for Adult Social Care or local third sector support agencies. Please see 'Exclusion Criteria' for further information.</i>

Has evidence of existing diagnosis of ASD/ADHD* been provided?

**To accept a referral for medication or support, evidence of existing diagnosis will be required.*

Please provide this with the referral.

Please tick:

☐

If referring for diagnostic assessment, please ask the person you are referring to complete all relevant 'Part B: Client Sections' (green sections) in full, including all questionnaires

Referrer checklist:	Tick
Part A: Referrer section completed	<input type="checkbox"/>
Part B: Relevant client sections completed	<input type="checkbox"/>
ASRS completed	<input type="checkbox"/>
AQ-10 completed	<input type="checkbox"/>
BFIS Quick Screen completed	<input type="checkbox"/>
Proof of existing diagnosis (if applicable) attached	<input type="checkbox"/>
Client has consented to the referral	<input type="checkbox"/>

Please note:

Referrals will not be processed unless all relevant sections are completed.

Please return completed forms to:

Email: NeSS@nottshc.nhs.uk / Post: Neurodevelopmental Specialist Service, The Pines, Highbury Hospital, Highbury Road, Nottingham, NG6 9DR

Guidance for referrer:

Part B of this form is intended for the individual being referred to complete themselves. In some instances, individuals may not be able to complete this independently; in these circumstances, please complete the required sections on their behalf. We are unable to accept referrals for diagnostic assessment without the relevant sections of Part B being completed.

NeSS Referral Part B: Client section for ADHD assessment

Attention and organisation

1. Tell us about any challenges you have with:

- concentration,
- organising yourself and your things,
- starting or finishing tasks,
- remembering tasks or activities.

2. How often is this a difficulty for you, and how does this affect your life?

Childhood examples (e.g. at school, at home, with friends and family):

Adulthood examples (e.g. at work, at home, at university, with friends and family):

Overactivity and impulse control

1. Tell us about times when you have:

- struggled to stay still when you were supposed to,
- acted without thinking of the consequences.

2. How often is this a difficulty for you, and how does this affect your life?

Childhood examples (e.g. at school, at home, with friends and family):

Adulthood examples (e.g. at work, at home, at university, with friends and family):

[Please now complete questionnaires on page 8-10](#)

NeSS Referral Part B: Client section for autism assessment

Social communication and interaction

1. Tell us about challenges with getting along with people and making friends
2. Tell us about any challenges in conversation, such as small talk or understanding jokes and sarcasm
3. Tell us about challenges understanding other people and their behaviour

Childhood examples (e.g. at school, at home, with friends and family):

Recent examples (e.g. at work, at home, at university, with friends and family):

Interests and routines

1. Tell us about any specific interests you have and how they impact on your life (this can be any interest but you may find it difficult to stop doing/talking about it)
2. Tell us about any set routines that impact on your daily life and how you deal with any changes to these

Childhood examples (e.g. at school, at home):

Recent examples (e.g. at work, at home, at university):

Your senses

1. Tell us about any sensitivity to noise, smell, taste, textures, light, or other sensory input

Childhood examples (e.g. at school, at home):

Recent examples (e.g. at work, at home, at university):

NeSS Referral: Please complete all questionnaires

Please answer the questions below, rating yourself on each of the criteria shown using the scale at the top of the page.
As you answer each question, **place an X in the box** that best describes how you have felt and conducted yourself OVER THE PAST 6 MONTHS.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project once the challenging parts have been done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often do you have difficulty getting things in order when you have to do a task that requires organisation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How often do you have problems remembering appointments or obligations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often	Very often

Place an X in the response box for each question.	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1. I often notice small sounds when others do not.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I usually concentrate more on the whole picture, rather than the small details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I find it easy to do more than one thing at once.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If there is an interruption, I can switch back to what I was doing very quickly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I find it easy to 'read between the lines' when someone is talking to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I know how to tell if someone listening to me is getting bored.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. When I'm reading a story I find it difficult to work out the characters' intentions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I like to collect information about categories of things (e.g. types of car, types of bird, types of train, types of plant etc).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I find it easy to work out what someone is thinking or feeling just by looking at their face.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I find it difficult to work out people's intentions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BFIS Quick Screen: Self-Report

Instructions

How much difficulty do you have functioning effectively in each of these major life activities? Please circle the number (or make **bold** if using electronic version) next to each item that best describes your difficulties in functioning DURING THE PAST 6 MONTHS. If the situation does not apply to you, please circle the 99 in the last column (under 'does not apply')

Major Life Activities	Not at all	Somewhat		Mild		Moderate			Severe		Does not apply
1. In your home life with your immediate family	0	1	2	3	4	5	6	7	8	9	99
2. In getting chores completed at home and managing your household	0	1	2	3	4	5	6	7	8	9	99
3. In your work or occupation	0	1	2	3	4	5	6	7	8	9	99
4. In your relationships with friends	0	1	2	3	4	5	6	7	8	9	99
5. In educational activities (college, night classes, occupational training)	0	1	2	3	4	5	6	7	8	9	99
6. In caring for yourself daily (dressing, bathing and hygiene, eating, sleeping, etc)	0	1	2	3	4	5	6	7	8	9	99
	Not at all	Somewhat		Mild		Moderate			Severe		Does not apply