SELF-REFERRAL FORM GUIDANCE

This self-referral form is for adults (aged 18 and over) who wish to be considered for an autism diagnostic assessment.

You can complete this form yourself, or with help from someone who knows you well. There are no right or wrong answers. The information you give will help us understand your experiences and decide whether an autism assessment is the right next step for you.

As part of the screening and assessment process, details on your developmental history will be asked, therefore please try and provide information from a parent, guardian or close relative who can recall your childhood experiences and challenges i.e. if there were any concerns about your communication, play, learning or social interactions and whether you experienced delayed language or motor development and required input from health professionals.

*Please let us know if you don't have any informants.

Please Note:

This form is not a diagnosis, and completing it does not guarantee an assessment. It helps us make sure the service is appropriate for your needs and supports us in planning any next steps.

What to Include

Please try to share examples from your life experiences and how these behaviours affect your day to day tasks and functioning. It's helpful if you can tell us about:

- Your social communication and interactions (e.g. making friends, understanding social cues)
- Patterns of behaviour, interests, or routines (e.g. strong interests, sensitivity to change)
- Sensory experiences (e.g. sensitivity to sound, light, or touch)
- Any mental health needs, learning differences, or existing diagnoses

We understand that not everyone has the same background or level of self-awareness. Please just share what feels accurate and relevant to you.

Confidentiality

All information you provide will be treated confidentially and in line with NHS Scotland data protection policies. We may contact your GP as part of the referral process, but only with your consent.

If You're Not Sure

If you're unsure about how to answer a question or whether this form is right for you, that's okay. Do your best, and let us know if you'd prefer to speak with someone instead.

Name:

Gender Identity (M/F/NB/Genderfluid/Agender/Prefer not to say):

Preferred Pronoun (He/She/They/Other):

Preferred Title (Mr/Mrs/Miss/Ms/Mx/Dr/Prof/Rev/None):

Date of Birth: CHI NO:

Address:

Telephone number:
Mobile number:
Email:

Preferred Communication Method e.g. email/telephone/letter/video call :

Do you have any accessibility needs or requirements we should be aware of e.g. mobility, sensory, cognitive processing, environmental, other?:

Is English your preferred language or do you require an interpreter, if so please state which language:

Date of referral:
GP: (name, address of contact:)

Do you consent to be assessed for Autism (Please tick for yes) ☐

Do you consent to the sharing of your medical information for the purposes of assessment?

(Please tick for yes) ☐

'Near Me' video sessions are most commonly used for diagnostic assessment. An invite link will be sent to your email or phone. Are you able to participate in this manner i.e. do you have access to a laptop, computer or phone which permits videocalls and do you have a safe, confidence space in order to speak freely with the clinician?

If you would prefer an in-person assessment, please tick 'No'.

Yes		No	

Other Health Professionals currently involved in your care: Please include name/contact details:

Psychiatrist	
Clinical Psychologist	
Support Worker	
Social Worker	
Community Psychiatric Nurse	
Community LD Nurse	
Any other Practitioner	

Current relationship status

Relationship status	Mark with an 'X'
Single	
In relationship	
Married	
Separated	
Divorced	
Widowed	

Current accommodation status

Accommodation status	Mark with an 'X'
Living alone	
Living with partner	
Living with parents	
Sheltered/temporary accommodation	
No fixed address	
Other (please specify), e.g. shared house:	

Education

School type	Mark with an 'X'
Mainstream state school	
Mainstream private school	
School for children with behavioural and/or emotional difficulties	
Specialist school for children with autism	
School for children with severe learning disabilities	
School for children with moderate learning disabilities	
School for children with physical disabilities and/or sensory impairments	
Language unit within a school	

Have you ever received a Statement of Special Educational Needs (SEN) or had an Educational Health Care Plan (EHCP) during your education?

Yes No

Please state your highest level of qualification to date:

Qualification	Mark with an 'X'
O level/CSE/GCSE/National 4's, 5's or equivalent	
Highers or equivalent	
A Level	
BTEC or equivalent	
NVQ	
Higher National Diploma	
First degree or equivalent professional qualification	
Higher degree (e.g. Masters, PhD)	
Other (please give details):	

Employment

Are you currently in paid employment? Yes No

If yes, what is your current job?

Have you had any problems gaining and/or maintain employment?

If so, do you have any ideas why this is the case?

Many people have asked for a referral to our service because they think they may be Autistic. If this is the case for you can you tell us why? i.e. Have you done any research or taken any self-assessment tools (e.g., AQ test)? what difficulties or challenges are you experiencing that you think may be linked to autism, why are you seeking a diagnosis now?

(Continue on a separate page if needed

Family History

Please detail any family members with diagnoses of mental health or developmental conditions (Some conditions may affect more than one person in the family. It can be very useful for us to be aware of this.)

Relationship to X (e.g. brother/aunt)	Diagnosis e.g. ADHD/Depression

Have you ever been referred to any other of the following professionals?

Psychiatrist	Yes	No
Clinical psychologist	Yes	No
Educational psychologist	Yes	No
Forensic psychologist	Yes	No
Nurse	Yes	No
Speech and language therapist	Yes	No
Occupational therapist	Yes	No
Social worker	Yes	No
Probation officer	Yes	No
Support worker	Yes	No
Disability employment advisor	Yes	No

Please give the names and addresses of any other clinicians or services you have seen (either in the past or currently for mental health or social care reasons (including social workers, probation officers, etc.) :

Name	Profession/service	Date seen	Current or past involvement

What formal diagnoses have you received from a professional?

Potential Risks

There are some other issues and experiences that we would like to know about that can help us get a better understanding of your situation in childhood.

We understand that these issues can be difficult to talk about, but please note these are important for us to know. If you can, we would appreciate some basic details.

Physical Abuse:

Emotional Abuse:

Sexual Abuse:

Poverty / Financial Deprivation:

Neglect:

Parental Physical Health:

Parental Mental Health:

Parental Separation:

Parent spending time in prison:

Other:

<u>There is some more sensitive information that we need to ensure the safety of both you and any clinician that see you. Please understand that this information will have no impact on the way that our team works with you.</u>

Have you ever felt suicidal? Yes No

If yes, have you ever planned or attempted suicide? Yes No

If yes, please give some details:

Have you ever been investigated by the Police or charged with a criminal offence? (E.g. cautions/convictions/court appearances/imprisonment)

Yes No

If yes, please give further details including charges and dates:

Have you ever been arrested for violent offences? Yes No

If yes, please give further details including charges and dates:

Have you ever been arrested for sex offences? Yes No

If yes, please give further details including charges and dates:

Have you ever received treatment for anger management? Yes
No

Thank you for this referral, please mark 'confidential' and send to:-

E-mail: nhsh.asd@nhs.scot

Or

Secretary, Adult Autism Diagnostic Service
Campbeltown Medical Practice, Stewart Road, Campbeltown, PA28 6AT