CONFIDENTIAL



TBF Ref no:

THE BUTTERFLY ROOM DIAGNOSTIC REFERRAL FORM

Please send your completed form to: diagnostics@thebutterflyroom.org

Please remember, if you have not already done so, to [[book](http://www.thebutterflyroom.org/contact.html)](https://calendly.com/asdscreening) your free consultation call with us to progress your referral

|  |  |  |
| --- | --- | --- |
| Patient Name: | DOB | GENDER : *please tick*Male Female Non-BinaryTransgender |
| Home Address: | **Please complete if appropriate:** Referrer’s Name:Referrer’s Address: |
| Telephone (mobile preferred) | Telephone: |
| Email: | Email:  |
| How did you hear about us?  |
| GP Name and Address:  |



Reason for referral

Please provide us with full details to enable us to have an understanding as to your concerns and reason for referral – please use separate sheets if required.

|  |
| --- |
| Please describe the behaviour(s) that concern you: |
| Have you ever been assessed for ASD previously? (please include dates and Assessment Team) |
| Please provide us with any other relevant information that we should be aware of (e.g. family changes, trauma) |



|  |
| --- |
| Please tell us any days/times that you are **NOT** available:**Please note that we will do our best to avoid any dates/times stated, but this may not always be possible based on our assessor’s availability.** **Please also be aware that due to extremely high demand, if you are unable to attend two appointments offered, you will be moved to the bottom of the waiting list.**  |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Registered Address: 68 Pondcroft Road, Knebworth, Herts, SG3 6DE The Yellow Butterfly Room T/as The Butterfly Room Children Services, company registered in England and Wales: 10611478