THE BUTTERFLY ROOM DIAGNOTIC REFERRAL FORM

Please complete this form fully and return to diagnostics@thebutterflyroom.org

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| --- | --- | --- |
| Child’s Name: | DOB: | Gender: Male / Female |
| Parent/Carer Name: | Referrer’s Name: |
| Child’s Home Address: | Referrer’s Address: |
| Home Telephone: | Telephone: |
| Mobile Number: | Email:  |

|  |
| --- |
| Child’s Diagnosis: |
| Family Status *(please circle)* Both Parents Lone Parent Step Carer (e.g. Foster Carer, Grandparent) |
| Is the child subject to a Child Protection Plan? Yes/No If yes please state category: | Is the child a ‘Looked After Child’? Yes/No If yes, please state type of placement: |
| Is the child known to and/or been known to Social Services? Yes/NoIf yes, please provide the social workers details including name, contact number and email address |
| Are there any safeguarding issues? Yes/No If yes, please give details: |
| Please provide details of any other agencies involved with the child:  |

|  |  |
| --- | --- |
| Child’s GP Name and Address: | GP Telephone Number: |
| Child’s School Name & Address: | Teacher Name: |
| School Year: |
| Telephone: | Email: |
| EP: | YES NO  | NAME: |
| LSA: | YES NO | NAME: |
| BEHAVIOUR SUPPORT | YES NO  | NAME: |

Reason for referral

**Please provide us with as much information as possible to enable us to have an understanding as to your concerns and reason for referral (please use separate sheets if required)**

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| --- |
| Please describe the behaviour(s) that concerns you: |
| Has your Child ever been assessed for ASD previously? *If so please give details including paediatrician name:*  |
| Please provide us with any other relevant information that we should be aware of (e.g. family changes, trauma) |
|  |
| Where did you hear about us? |

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

 Referrer

**Before we are able to accept and process any referral, we require the child’s parent/carer to confirm that they are aware and consent to, this referral being made.**

*Whilst by law, we only need to obtain consent from one party with parental responsibility, by signing your consent to therapy, we are assuming that both parents/carers are giving their consent, if this is* ***NOT*** *the case please tick to indicate this*

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

 Parent/Carer

Parental Consents

**Parents/Carers must read, complete and sign the following section. Referrals CANNOT be accepted and processed without this information and consent.**

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sharing of Information

I understand that personal information is held about me and/or my child. Personal information is made up of basic and additional information - basic information means name, address, gender, date of birth, school attended, GP, parents or primary carer etc. Additional information includes any identified needs you/your child may have and how they may be met. It may include relevant sensitive information such as ethnic origin, religion, mental health, sexual health, offences alleged or committed etc.

Yes, I understand and consent to personal information being held about me/my child

In order to provide your child with the best treatment, occasionally we may need to share this information with other services including healthcare and/or education professionals, **this will be discussed with you beforehand**.

Yes, I agree to my/my child’s basic and/or additional information being shared between services

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

 Parent/Carer