**JADES Referral Form**

**This referral form must be fully completed and signed by your child’s G.P**

**and early years/school professional.**

**Guidance**

Step 1. Referrer (first professional contacted) to complete the screening tool in discussion with

parent/carer (Section A).

**If child scores below screening tool threshold, a JADES referral may not be indicated**

Step 2. Parent/carer to complete sections B, C & D

Step 3. Early Years/school professional to complete section C in discussion with parent/carer and

sign form.

If a child / young person **is not in any educational setting** (e.g. pre-school, nursery, school, college), section C is to be completed by a parent/carer alone.

Support can also be obtained by a parent/carer from their child’s Health Visitor, School Nurse or another relevant Health Professional, involved with their child’s care.

Step 4. G.P. to review referral, provide any further information to sections D & E and sign form.

**Referrer details – both referrers must complete and sign**

**Early Years/ School/ Education professional:**

|  |  |
| --- | --- |
| Name of Referrer: | |
| Signature: | Date: |
| Address: Postcode:    Telephone no: Email: | |

**G.P (child must be registered with a West Essex surgery):**

|  |  |
| --- | --- |
| Name of Referrer: | Role: |
| Signature: | Date: |
| Address: Postcode:    Telephone no: Email: | |

**Section A - Screening Tool**

Referrer to complete the screening tool in discussion with parent/carer and include score below. Screening tools can be found at:

<https://essexfamilywellbeing.co.uk/our-services/jades-journey-of-autism-diagnosis-and-early-support/>

Failure to include an additional screen assessment will result in rejection of your referral.

Screening tool children under 4 years complete:

* M-CHAT Autism questionnaire.

Score …………….. (score of 8 or above consider referral to JADES)

Screening tool children over 4 years complete:

* AQ10 questionnaire

Score ………………(score of 6 or above consider referral to JADES)

**Section B**

1. **Child / Young Person’s Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child’s name (including preferred name): | | | Date of birth: | |
| NHS Number: | | | Sex: | |
| Address:  Postcode: | | | | |
| Telephone no: | | | | |
| Parent/Guardian Name: | Address if different from above: | | | Parental Responsibility:  Yes / No |
| Mobile no: Email address: | | | | |
| Parent/Guardian Name: | Address if different from above: | | | Parental Responsibility:  Yes / No |
| Mobile no: Email address: | | | | |
| Child’s first language/preferred method of  communication: | | Parent’s first language/preferred method of  communication: | | |
| Interpreter/Signer required (please state): Yes / No | | | | |

1. **Social Care Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Does your child / young person have a Child Protection Plan?  **YES / NO** | Has your child ever been on a Child in Need or Child Protection Plan?  **YES / NO**  When: | Are you the child/young person’s foster carer?  **YES / NO** | Does your family currently have support from a social worker?  **YES / NO**  Name:  Telephone: |

1. **Child / Young Person’s Family and Social History**

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| --- |
| **Nature of concerns**  Please tell us when you first thought that your child might be Autistic. |
| **Family History**  Please tell us about anyone in the family who has or is suspected to have learning difficulties, ADHD, Autism, mental health difficulties, developmental problems or language problems.  Comments: |
| **Past Experiences**  Please tell us about any significant, traumatic or adverse events in your child’s life, which could possibly be relevant to your child’s emotional wellbeing and behaviour.  Comments: |

**Section C**

1. **Early Years / Education Setting**

|  |  |
| --- | --- |
| School/Early Years setting: | SENCo: |
| Do you have any concerns about the child/young person’s progress in school? If yes, please provide details:  Does the child/young person receive support in school? If yes, please provide details:  Does the child/young person have a One Plan or Education Health and Care Plan? | |

1. **Please provide a full description of your child at home and in their early years/school setting below.**

|  |  |
| --- | --- |
| **Area of behaviour** | **Comments and examples** |
| **Spoken language** e.g.  How does your child use language (e.g. sounds, single words, short phrases, sentences)?  Is there anything unusual about the way your child talks? If yes, please tell us more. | **Home:** |
| **School/Setting:** |
| **Social use of language** e.g.  How does your child ask for things they need, engage in back and forth conversation, express their thoughts and feelings? | **Home:** |
| **School/Setting:** |
| **Responding to others** e.g.  Does your child acknowledge and respond to others in conversation and play?  Does your child respond to instructions and requests? | **Home:** |
| **School/Setting:** |
| **Interacting with others** e.g.  Do they seek others to play or talk with?  Do they have friends?  Do share with others? | **Home:** |
| **School/Setting:** |
| **Empathy and emotions** e.g.  How does your child respond to other people’s feelings?  Does your child show empathy or offer comfort to others? | **Home:** |
| **School/Setting:** |
| **Eye contact, facial expression and gestures** e.g.  Does your child make and sustain eye contact with others?  Comment on your child’s use of facial expressions.  Does your child use natural gestures (e.g. nod/shake of head, waving, pointing, shrugging)? Please give examples. | **Home:** |
| **School/Setting:** |
| **Play and imagination** e.g. Describe your child’s play and preferred activities.  Do they show imagination? | **Home:** |
| **School/Setting:** |
| **Unusual and restricted interests** e.g.  Does your child have any obsessions or over-riding interests? Please comment. | **Home:** |
| **School/Setting:** |
| **Rigid and/or repetitive thinking including routines and rituals** e.g.  Does your child insist on routines? Please comment.  How does your child manage change? | **Home:** |
| **School/Setting:** |
| **Does your child use repetitive body movements?** e.g. hand flapping, spinning, jumping, rocking, twisting fingers. Please comment. | **Home:** |
| **School/Setting:** |
| **Over or under reaction to sensory stimuli** e.g.  Does your child have any issues with the way objects or people smell, feel, taste, sound or look? If yes, please tell us more. | **Home:** |
| **School/Setting:** |
| **Emotional wellbeing/behaviour** e.g.  Can your child calm down easily?  Does your child self-harm? | **Home:** |
| **School/Setting:** |

**Section D**

**7. Child’s Medical History**

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| --- |
| **Birth and Early Development:**  Were there any difficulties during pregnancy (include any medications and illness)?  Comments:  Were there any complications at birth (including if your child was born prematurely, admission to Neonatal unit, any treatment involved)?  Comments:  Were there any concerns about your child’s early developmental milestones? Please indicate age at which each skill was attained if known. (Some details may be available in your child’s Red Book.)   * Roll over * Sitting up unsupported * Smile * Walking independently * First single words (what were they)   Has your child ever experienced a loss of any developmental milestones e.g. talking, walking, caring for themselves? If so, which skills were lost and when? Have they now returned?  Comments:  **Current Health**  List any medication your child is taking. Please tell us the current dosage, when the medication was started and prescribed by which professional.  Comments:  Do you have any concerns about your child’s general health? Please include any past operations, hospital admissions and treatment involved. Please give the name of the doctor/consultant, team and hospital.  Comments:  Is your child under assessment or waiting for an appointment with any other hospital?  Comments: |

**8. General Development:**

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| --- |
| Do you have any concerns about your child’s fine motor skills? (e.g. pen/scissor control, tying shoe laces, doing up buttons) or gross motor skills (e.g. walking, running, jumping, pedalling a bike).  Comments:  Is your child able to manage their own care needs without your support? e.g. going to the toilet, washing, brushing teeth, personal hygiene and organisation.  Comments:  Do you have any concerns about your child’s ability to concentrate? How easily can they shift their attention away from something they are doing? Do they have a short span or attention or get distracted easily?  Comments:  Do you have any concerns about your child’s general mood and/or behaviour?  Comments:  Please tell us about your child’s sleeping patterns. Please include details of any sleep routines or methods to help manage sleep.  Comments:  Does your child have an awareness of danger and consequences?  Comments:  Do you have any concerns about your child’s diet, appetite or eating behaviours?  Comments: |

**Section E (G.P. only)**

**9. Other G.P. medical information:**

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| --- |
| Please add any further medically relevant information. |
| Is there any other diagnosis being considered to explain current symptoms? |

**9. Additional Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please tick below any other services who have been involved in the child / young person’s support: | | | | |
| Audiologist  **□** | Optician  **□** | Health Visitor  **□** | CAMHS (Child and Adolescent Mental Health Service)  **□** | Educational psychologist  **□** |
| Speech and Language Therapist  **□** | Occupational Therapist  **□** | Physiotherapist  **□** | Paediatrician  **□** | School nurse  **□** |
| Children’s Learning Disability Service (CLDS)  **□** | Social Services  **□** | Specialist teacher  **□** | Other  **□** |  |
| **Please attach any reports from the agencies stated above with this referral form** | | | | | |

**10. Consent:**

The parent/carer consents to:

* Referral for a JADES assessment
* The JADES team obtaining information from other agencies including the school/education setting
* The JADES team sharing information with other professionals
* The JADES team observing their child in an educational setting if this is required

|  |  |  |
| --- | --- | --- |
| **Parent/Carer’s name:** | **Parent/carer’s signature:** | **Date:** |

**Thank you for your cooperation, please return to:**

JADES Administrator,

Florence Nightingale Child Development Centre,

Minton Lane,

Harlow.

CM17 9TG.

Or by Email to: [VCL.essexwest-JADES@nhs.net](mailto:VCL.essexwest-JADES@nhs.net)

**Please ensure you have included the following:**

□ Relevant screen (M-CHAT or AQ10)

□ Fully completed referral form with signatures from parent/carer, education and G.P.

□ Any supporting reports/documents you think would be helpful to assist this referral