FNH035006

Northern Health

NORTHERN AUTISM SPECTRUM DISORDER ASSESSMENT CLINIC REFERRAL

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: _____

- ***All sections of this Northern Autism Spectrum Disorder Assessment Clinic (NASDAC) Referral form MUST be completed or the referral will be rejected.***
- Referrals are only accepted from Paediatricians (at Northern Health or externally) and internal Northern Health Allied Health professionals
- NASDAC is for children living within the Northern catchment area
- NASDAC is for children prior to school entry
- NASDAC uses Medicare options for ASD assessment
- Attached to this referral must be Audiology results, a comprehensive Paediatrician report/letter and an allied health report/letter (e.g. speech pathologist or key worker)

Date of Referral:	_____/_____/_____	Date of Birth: _____/_____/_____
Child's Name:		❑ Male ❑ Female
Address:		
Child's Language(s):		Interpreter required: ❑ Yes ❑ No
Parent / Caregiver 1:	Name:	Relationship:
	Address:	Phone:
	Language(s): ❑ English ❑ Other:	Interpreter required: ❑ Yes ❑ No
	Email:	
Parent / Caregiver 2:	Name:	Relationship:
	Address:	Phone:
	Language(s): ❑ English ❑ Other:	Interpreter required: ❑ Yes ❑ No
	Email:	
Child lives with:	❑ Both parents ❑ Other:	
Does the child identify as:	❑ Aboriginal ❑ Torres Strait Islander Origin ❑ Neither ❑ Both Aboriginal and Torres Strait Islander Origin	
Do you want to make an Aboriginal Liaison Officer referral?		❑ Yes ❑ No
Country of Birth:	❑ Australia ❑ Other:	
Is there Child Protection or Child First / Victorian Aboriginal Child Care Agency involvement? ❑ No ❑ Previously ❑ Yes Details:		Are there any Court Orders/Custody Arrangements? ❑ No ❑ Yes Details:
Parent / carer consent is required. Have you obtained consent for this referral?		❑ Yes ❑ No
Are there any barriers to the family attending appointments? ❑ Yes ❑ No. Comment:		

Area(s) of concern (please tick):

❑ Communication	❑ Language	❑ Speech	❑ Social & Interaction Skills
❑ Physical Development/Motor Skills	❑ Behaviour	❑ Attention	❑ Learning
❑ Feeding Skills	❑ Nutrition / diet / growth		❑ Self-care skills
❑ Play skills	❑ Hyper or Hypo response to sensory input		❑ Other:

Please provide details:

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Reason for a multi-disciplinary team assessment? What is your differential diagnosis?
ASD concerns:
Any other relevant information (e.g. preterm, medical history, diagnoses, family history etc.):

Previous Assessments:		
Audiology	❑ Yes Service: _____ Date: ___/___/___ Normal results: ❑ Yes ❑ No Comments:	
	Please note: If referring to NASDAC, the child must have already had a hearing assessment	
Vision	❑ No ❑ Referred / awaiting. Service: _____ ❑ Yes. Service: _____	Normal results: ❑ Yes ❑ No Date: ___/___/___

Paediatrician:		Consent to contact: ❑ Yes ❑ No ❑ N/A
Name:		
Clinic Name:		
Phone:		Last review date: ___/___/___
Email:		

Other Professionals Involved:			
GP	Name: Clinic Name: Address: Phone: Email:		Consent to contact: ❑ Yes ❑ No
Community Health	❑ No referral made *OR* ❑ Referred to: On (date): ___/___/___	*OR* ❑ Accessing Name: Discipline: Service Name: Address: Phone: Email:	Consent to contact: ❑ Yes ❑ No

Name: _____ Signature: _____

Designation: _____ Date: _____/_____/_____ Time: _____:_____

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DATE OF BIRTH: _____/_____/_____ SEX: _____

National Disability Insurance Scheme (NDIS)/ Early Childhood Early Intervention (ECEI)	❑ No referral made *OR* ❑ Referred (date): ___/___/___	*OR* ❑ Accessing Key Worker Name: Service Name: Address: Phone: Email:	Consent to contact: ❑ Yes ❑ No
Therapist/s	❑ No referral made *OR* ❑ Referred to: On (date): ___/___/___	*OR* ❑ Accessing Name: Discipline: Service Name: Address: Phone: Email:	Consent to contact: ❑ Yes ❑ No
	❑ No referral made *OR* ❑ Referred to: On (date): ___/___/___	*OR* ❑ Accessing Name: Discipline: Service Name: Address: Phone: Email:	Consent to contact: ❑ Yes ❑ No

Education Setting attended? (e.g. childcare) ❑ Yes ❑ No		Consent to contact: ❑ Yes ❑ No ❑ N/A
Centre Name:		
Teacher name:		
Address:		
Phone:		Email:

Referrer Name:		Signed:
Profession:		Provider No: ❑ N/A
Agency/Service:		
Address:		
Phone:		Email:

Please return this form to: **Community Access Service (CAS)**
Email: community.access.helpdesk@nh.org.au
Fax: 9495 3510
Phone: 9495 3443 (Option 1)

Checklist - *Please attach completed assessments/letters/reports before sending this referral.*	
Audiology assessment report	❑ Yes
Allied Health Assessment (e.g. key worker letter, developmental assessment, language assessment or cognitive assessment)	❑ Yes
Paediatrician letter/report	❑ Yes
Investigations	❑ Yes ❑ N/A
Other:	

Name: _____ Signature: _____

Designation: _____ Date: _____/_____/_____ Time: _____:_____

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