Right to Choose Referral Form: Private Therapy Clinic – Children and Young People (CYP) ADHD/Autism Assessments

Private Therapy Clinic holds an NHS contract to provide autism and ADHD assessments for children and young people. Under the NHS Right to Choose, this means patients anywhere in England can ask their GP to refer them to us.

Please note there are 3 sections to this referral form: Section 1 for the GP, Section 2 for the parent/carer and Section 3 for the school/education setting. We need all three sections at the point of referral.

Instructions for GPs:

- GP should complete Section 1 (GP / Referrer Section) for the child or young person
- Please make the referral through e-RS, or send the completed form (all three sections) securely to privatetherapy.clinic@nhs.net
- Contact nhs@theprivatetherapyclinic.co.uk for assistance
- Please ensure if this patient is on a current waiting list that you inform the Provider of this referral to remove them from their waiting list.
- GPs are reminded that should a patient request a referral to an RTC Provider that you must assure yourself as per the RTC National legislation: https://www.gov.uk/government/publications/the-nhs-choice-framework
- **Please note, only referrals made by the GP practice will be accepted.**

Instructions for parents and carers:

- Parents/carers should complete Section 2 (Parent/Carer Questionnaire) for the child or young person
- Please give Section 3 (School/Education Setting Questionnaire) to the child's school or education setting to complete. The school only needs Section 3.
- Once completed, return all three sections to the GP practice so they can complete their section (if not already completed) and make the referral.
- If printing, please write clearly in black ink, tick (✓) the boxes that apply and return every page.
- **Please note, only referrals made by the GP practice will be accepted.**

Right to Choose CYP ADHD & ASD Assessment Referral Form

SECTION 1: GP / REFERRER SECTION

CHILD / YOUNG PERSON'S DETAILS:

Name:		**Date of Birth:**	
Address:			
NHS No:			
Contact Details for Parent/s or Carer:	Mobile:		
	Home:		
	Alternate:		
	Email:		
Please name **everyone** who has parental responsibility for the Child / Young Person:			
Do both parents / carers who have parental responsibility live in the family home:			☐ Yes ☐ No
If no can information including Child / Young Person's address be shared with both parents / carers:			☐ Yes ☐ No
Please provide the details of parent / carer not living in the family home if information can be shared:			
Would an interpreter be required for an appointment?			☐ Yes ☐ No
If yes, please advise of language:			
GP Surgery:	Name:		

REFERRER'S DETAILS:

Name:	
Job Title:	
Tel:	
Email:	
Address:	
e-RS UBRN (if referred via e-RS):	
GP practice ODS code:	
Date completed:	

What is the primary reason for this referral? (Tick ONE)	
Autism - Social Communication and Interaction difficulties	
ADHD - Attention and hyperactivity out of keeping with developmental level	

Relating to BOTH autism - social communication and interaction difficulties AND ADHD - attention and hyperactivity out of keeping with developmental level.	
Other. Please specify:	

RELEVANT INFORMATION

Is the Child / Young Person and/or family accessing or open to Social Care, now or in the past? E.g. receives help from an early help / family support service, or has a child in need or child protection plan?	☐ Yes ☐ No
If yes, please provide the details:	
If yes, please provide the details of their main contact e.g. Social Worker or family practitioner etc:	
Name:	
Tel:	
Email:	
Are they currently on a Child Protection Plan:	☐ Yes ☐ No

CLINICAL INFORMATION

Is the Child / Young Person currently taking any medication (including any previous ADHD medication)?	☐ Yes ☐ No
If yes, please list medication, dose and frequency:	
Does the Child / Young Person have any known allergies?	☐ Yes ☐ No
If yes, please give details:	
Is the Child / Young Person currently open to, or previously known to, CAMHS / children's mental health services?	☐ Yes ☐ No
If yes, please give the service name, dates and reason for involvement:	
Is the Child / Young Person currently open to, or previously known to, community paediatrics or another neurodevelopmental service?	☐ Yes ☐ No

If yes, please give the service name, dates and outcome:	
Is the Child / Young Person currently on a waiting list for an autism and/or ADHD assessment with any other service (including another Right to Choose provider)?	☐ Yes ☐ No
If yes, please give the service name. Please let that service know about this referral so the Child / Young Person can be removed from their waiting list:	
Does the Child / Young Person have any other known diagnoses, e.g. learning disability, epilepsy, hearing or vision impairment, genetic conditions?	☐ Yes ☐ No
If yes, please give details:	
Are there any current risk concerns, e.g. self-harm, suicidal thoughts, risk to others?	☐ Yes ☐ No
If yes, please give details and any actions taken:	
Physical health baseline (most recent recorded, if available):	
Height (cm): _____ Date recorded: _____	
Weight (kg): _____ Date recorded: _____	
Blood pressure: _____ Date recorded: _____	
Pulse / heart rate: _____ Date recorded: _____	
Is there any personal history of heart problems, fainting, palpitations or unexplained chest pain?	☐ Yes ☐ No
If yes, please give details:	
Is there any family history of heart problems, or sudden or unexplained death, in a close relative under the age of 40?	☐ Yes ☐ No
If yes, please give details:	

Has the Child / Young Person had a private assessment / assessment from a previous area for a neurodevelopmental disorder?	☐ Yes ☐ No ☐ Unknown
If yes, please provide the details below and attach the report:	
We understand some families may seek a private diagnosis. *We ask that reports are shared with our service to outline the best pathway and support for the Child / Young Person.*	
Please add any other relevant information which you feel is important for us to know when considering this Child / Young Person:	

Section 2: Parent/Carer Questionnaire for an Autism and/or ADHD assessment via Right to Choose

Once complete – forms should be returned to the referrer (GP).
Parents/carers should ensure they take a copy for their records before the referral is submitted.

This parent/carer questionnaire is required to support the referral for an autism and / or ADHD assessment via the Right to Choose scheme. The information provided will determine the assessment(s) required. The more information you can provide the better.

The school/educational setting questionnaire should be passed to your child/young person's school or educational setting for completion, before the complete form is returned to your GP for submission. The school only needs Section 3.

If you need help filling out the form please talk with your school / educational setting, family support worker, or social worker.

What is your preferred method of communication? (Tick one) ✓			
Link by SMS		Attachment by Email	
Link by Email		Copy by Post	

Sharing information	
Are you happy to share your Child / Young Person's record with other health services who are involved with your Child / Young Person's care?	☐ Yes ☐ No
Are you happy to have access to the records held by other health services involved in your Child / Young Person's care?	☐ Yes ☐ No
Are you happy to share information with the child / young person's educational setting e.g. SENCO and the local authority?	☐ Yes ☐ No
An onward referral may be made after your appointment please check the below:	
Do you consent to us viewing your Child / Young Person's shared care record (the electronic patient record shared between NHS services, such as your GP)?	☐ Yes ☐ No
Do you consent to us adding information relating to your Child / Young Person's care to their shared care record which may be viewed by other NHS professionals such as your/their GP?	☐ Yes ☐ No
Does the Child / Young Person (aged 13 and over) consent to their information being shared by parents / carers and their educational settings?	☐ Yes ☐ No
CONSENT TO REFERRAL:	

Do you agree to this referral being made:	☐ Yes ☐ No
Does the Child / Young Person agree to this referral being made:	☐ Yes ☐ No ☐ Not applicable
Please include further information on Child / Young Person's response:	
Please ensure all consent questions are answered above to avoid delays.	
If you are completing this form by hand, please sign below. If you are completing it electronically, type your name in the signature box.	
SIGN:	
PRINT:	
RELATIONSHIP TO CHILD / YOUNG PERSON:	
DATE:	

MEDICAL HISTORY:

1. Were there any complications during pregnancy?	☐ Yes ☐ No
Please give details:	
2. Were there any complications at the birth?	☐ Yes ☐ No
Please give details:	
3. Was your child born before 37 weeks?	☐ Yes ☐ No
Please give details:	
4. Did they meet their developmental milestones?	☐ Yes ☐ No
If NO, please give brief detail of what the difficulties were/are:	
5. Does your child / young person have any physical or health difficulties or diagnoses?	☐ Yes ☐ No
Please give details:	

6. Are there any concerns regarding your child / young person's diet and/or appetite?	☐ Yes ☐ No
Please give details:	
7. Are there any concerns regarding your child / young person's sleep?	☐ Yes ☐ No
Please give details:	
8. Are there any concerns regarding your child / young person's self-care skills e.g. getting dressed, washing, toileting?	☐ Yes ☐ No
Please give details:	
9. Are there any concerns regarding the following:	☐ Yes ☐ No
• Gross motor skills (large muscle movements e.g. crawling, walking, jumping, climbing): ☐ Yes ☐ No • Fine motor skills (small muscle movements e.g. using buttons and zips, holding a pencil or fork, using scissors): ☐ Yes ☐ No • Balance and coordination: ☐ Yes ☐ No	
10. Do you have any concerns about the way your child/ young person understands language?	☐ Yes ☐ No
Please give details:	
11. Which best describes the way your child/young person speaks to you?	
☐ Not yet speaking ☐ Single words and/ or short phrases ☐ Full sentences ☐ Full conversations	
12. Is there any family history of autism, ADHD, learning disability, or other neurodevelopmental or mental health conditions?	☐ Yes ☐ No

Please give details, including the relationship to the Child / Young Person:

FAMILY STRUCTURE AND SIGNIFICANT LIFE EVENTS

13. Please tell us who lives at home with your Child / Young Person, their age and relationship to the Child / Young Person (e.g. sibling, parent, stepparent, carer). Also tell us about other significant relationships with extended family who live locally to you.	
14. Have there been any relationship breakdowns, including separation and divorce?	☐ Yes ☐ No
15. Has there ever been domestic abuse / violence in the family?	☐ Yes ☐ No
16. Is the Child/Young Person a Child Looked After?	☐ Yes ☐ No
17. What are your Child / Young Person's strengths and interests?	
18. What is your Child / Young Person's view of their difficulties?	
19. How do the Child / Young Person's difficulties affect the family?	

20. Have you attended a course or workshop to understand your child / young person's needs, if so, how long ago and which course did you attend?	☐ Yes ☐ No
21. Have you accessed any relevant support e.g. helplines, groups, charities? If yes which ones?	☐ Yes ☐ No
22. Has the Child / Young Person had a private assessment for autism, ADHD, or similar / related conditions?	☐ Yes ☐ No
If yes, please provide the details below and attach the report. We understand some families may seek a private diagnosis. We ask that reports are shared with our service to outline the best pathway and support for the Child / Young Person.	

EDUCATION SETTING DETAILS, INCLUDING NURSERY, SCHOOL, COLLEGE

23. Does the child / young person attend an educational setting?		☐ Yes ☐ No
If yes, please complete details below;		
Educational Setting Contact Details:	Name:	
	Address:	
	Phone Number:	
	Email:	
If no, when was the last time they attended an educational setting (please tick one option):		

Less than six months ago More than six months ago Never	☐ ☐ ☐

If less than six months ago, please provide the educational setting contact details below;

Educational Setting Contact Details:	Name	
	Address:	
	Phone Number:	
	Email:	

REASONABLE ADJUSTMENTS

24. Does the child / young person need any reasonable adjustments? E.g. appointments in person rather than virtual, etc.
25. Do the parents / carers need any reasonable adjustments? E.g. call rather than text messages, etc.

CONCERNS / AREAS OF DIFFERENCE

Parental / Carer Concerns: Please highlight your level of concern and give details.	
26. Communication skills:	☐None ☐Some ☐Significant
Please provide details:	
27. Social Interaction with peers and managing relationships:	☐None ☐Some ☐Significant
Please provide details:	
28. Behaviour that concerns or challenges others:	☐None ☐Some ☐Significant
Please provide details:	

29. Intense or specific interests/play:	☐None ☐Some ☐Significant
Please provide details:	
30. Repetitive Behaviours:	☐None ☐Some ☐Significant
Please provide details:	
31. Routines/challenges with changes:	☐None ☐Some ☐Significant
Please provide details:	
32. Sensory seeking/avoidance:	☐None ☐Some ☐Significant
Please provide details:	
33. Mental Health:	☐None ☐Some ☐Significant
Please provide details:	
34. Emotional Responsiveness and well-being:	☐None ☐Some ☐Significant
Please provide details:	
35. Does your Child / Young Person often find it difficult to give close attention to details; or makes careless mistakes with their homework?	☐None ☐Some ☐Significant
Please give examples:	
36. Does your Child / Young Person often have difficulties sustaining attention with tasks and play activities?	☐None ☐Some ☐Significant
Please give examples:	
37. Does your Child / Young Person often not seem to listen when spoken to directly, for example their mind seems elsewhere?	☐None ☐Some ☐Significant

Please give examples:	
38. Does your Child / Young Person often not follow through on instructions, or fail to finish their schoolwork, chores or duties? For example, do they start tasks and then quickly lose focus?	☐None ☐Some ☐Significant
Please give examples:	
39. Does your Child / Young Person have difficulties organising tasks and activities, for example: difficulty keeping materials and belongings in order, messy and disorganised?	☐None ☐Some ☐Significant
Please give examples:	
40. Does your Child / Young Person often avoid, dislike, or seem reluctant to engage in tasks that require sustained mental effort, for example: homework or schoolwork, easily distracted?	☐None ☐Some ☐Significant
Please give examples:	
41. Does your Child / Young Person often lose things necessary for a task or activity, for example: pens, pencils, books, tools, paperwork, or PE kit?	☐None ☐Some ☐Significant
Please give examples:	
42. Does your Child / Young Person become easily distracted by irrelevant or unrelated things that have no relation to what they are supposed to be doing, for example: when studying or concentrating on a task?	☐None ☐Some ☐Significant
Please give examples:	
43. Does your Child / Young Person often forget daily activities, for example: doing chores, their school timetable, timings, when they are supposed to meet you or others?	☐None ☐Some ☐Significant

Please give examples:	
44. Does your Child / Young Person fidget, squirm or leave their seat in situations when you would expect them to remain seated or sit still?	☐None ☐Some ☐Significant
Please give examples:	
45. Does your Child / Young Person often act as if "driven by a motor", always seem full of energy, or have difficulty waiting their turn?	☐None ☐Some ☐Significant
Please give examples:	
46. Does your Child / Young Person talk excessively, blurt out answers or interrupt conversations?	☐None ☐Some ☐Significant
Please give examples:	

47. SNAP -IV Parent / Carer 18-Item Rating Scale, James M. Swanson PhD
For each item, check the column which best describes this child/ young person:

	Not at all	Just a little	Quite a bit	Very much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
10. Often fidgets with hands or feet or squirms in seat				

11. Often leaves seat in classroom or in other situations in which remaining seated is expected				
12. Often runs about or climbs excessively in situations in which it is inappropriate				
13. Often has difficulty playing or engaging in leisure activities quietly				
14. Often is “on the go” or often acts as if “driven by a motor”				
15. Often talks excessively				
16. Often blurts out answers before questions have been completed				
17. Often has difficulty awaiting turn				
18. Often interrupts or intrudes on others (e.g., butts into conversations/ games)				

Section 3: School/Education Setting Questionnaire for an Autism and/or ADHD assessment

Once complete – please return this section to the parent/carer, or directly to the child's GP practice, so it can be sent with the referral.

Parents/carers should ensure they take a copy for their records before the referral is submitted.

This school/educational setting questionnaire is required to support a referral for an autism and / or ADHD assessment. Please could you ensure where possible all parts of this form are completed.

EDUCATION SETTING QUESTIONNAIRE

CHILD / YOUNG PERSON'S DETAILS:

Name:		**Date of Birth:**	
Address:			
NHS No:			

Name of person completing questionnaire:	
Role of person completing questionnaire:	
Education setting:	
Date of Completion:	
Current Year Group of Child / Young Person?	
Are they out of year group? **If yes, which year group should they be in?**	

Please provide the details of your SENCo/INCo/SEND Lead:	
Name/Role:	
Tel:	
Email:	

1. Describe the Child / Young Person's strengths:

2. Challenges seen in school including how long they have been present:
3. If possible to obtain, what is the Child / Young Person's view on their potential differences?

ACADEMIC PROGRESS

Please complete the relevant section for the child based on their age / year group, ticking or circling the level that applies.

4. EARLY YEARS FOUNDATION STAGE

Communication and Language	☐ Emerging ☐ Expected
Physical development	☐ Emerging ☐ Expected
Personal, social and emotional development	☐ Emerging ☐ Expected

5. PRIMARY

Reading	☐ PRE - Pre-Curriculum Expectations ☐ WTS - Working Towards the Curriculum Expectations ☐ EXS - Working at the Expected Standard ☐ GDS - Working at Greater Depth
Writing	☐ PRE ☐ WTS ☐ EXS ☐ GDS
Maths	☐ PRE ☐ WTS ☐ EXS ☐ GDS

6. SECONDARY

	Current attainment	Key stage equivalent
English	Year 1/2/3/4/5/6/7/8/9/10/11	KS 1/2/3/4
Maths	Year 1/2/3/4/5/6/7/8/9/10/11	KS 1/2/3/4
Science	Year 1/2/3/4/5/6/7/8/9/10/11	KS 1/2/3/4

7. CAT scores (if available):

Verbal reasoning	
Non-verbal reasoning	
Quantitative reasoning	

ACADEMIC ATTAINMENT

8. Is this Child / Young Person's academic attainment in line with their peers:	☐ Yes ☐ No
If no please quantify the gap using school measures, including current level.	
9. Is this Child / Young Person's academic attainment in line with their ability:	☐ Yes ☐ No
If no, what do you see to be the barriers and provide evidence for your reasons:	
10. Is this Child / Young Person on a reduced timetable:	☐ Yes ☐ No
If yes, please give details of the reduced timetable and reasons why:	
11. Is the Child / Young Person spending time outside the classroom on a regular basis:	☐ Yes ☐ No
If yes, please give details of where and why:	
12. Is school attendance an issue:	☐ Yes ☐ No
If yes, please specify with reasons why:	
13. Is this Child / Young Person in receipt of an EHCP or has additional support in school:	☐ Yes ☐ No
If yes, please give detail:	

14. Are there any current or previous Safeguarding concerns in relation to this Child / Young Person and the family:	☐ Yes ☐ No

If yes, please give detail:	
15. Is this Child / Young Person open to Children's Services e.g. CP plan/ CIN plan:	☐ Yes ☐ No
If yes, please give detail:	

SUPPORT AND STRATEGIES

16. Please list what support and strategies are currently being implemented at school. Consider what effect these interventions have had. **If available, please attach any relevant SEN support plan, provision map, individual education plan or similar report with this referral.**
17. Please list support and strategies that have been offered and / or taken up by the family, including input from local family support worker, with name and dates if available.

CONCERNS/AREAS OF DIFFERENCE

Please highlight your level of concern and give details.	
18. Communication skills:	☐None ☐Some ☐Significant
Please provide details:	
19. Social Interaction with peers and managing relationships:	☐None ☐Some ☐Significant
Please provide details:	
20. Behaviour that concerns or challenges others:	☐None ☐Some ☐Significant

Please describe:	
21. Intense or specific interests/play:	☐None ☐Some ☐Significant
Please provide details:	
22. Repetitive Behaviours:	☐None ☐Some ☐Significant
Please provide details:	
23. Routines/challenges with changes:	☐None ☐Some ☐Significant
Please provide details:	
24. Sensory seeking/avoidance:	☐None ☐Some ☐Significant
Please provide details:	
25. Mental Health:	☐None ☐Some ☐Significant
Please provide details:	
26. Ability to recognise emotions and emotional responsiveness:	☐None ☐Some ☐Significant
Please provide details:	
***27.* Attention:**	
Do they respond to their name or other prompts?	☐ Yes ☐ No

Do they seem to be listening when spoken to?	☐ Yes ☐ No
Do they flit between activities?	☐ Yes ☐ No
Please comment on their attention to detail and thoroughness of work:	
28. **Ability to concentrate and sustain focus:**	
Is the Child / Young Person's ability to concentrate and sustain focus a concern in school?	☐ Yes ☐ No
Please describe:	
29. **Organisation skills, time management, ability to plan and start tasks, working memory and adaptable thinking:**	
Please describe any strengths/concerns:	
30. Level of activity, in both large and small movements:	
Are they calm and still?	☐ Yes ☐ No
Do they have difficulty remaining seated?	☐ Yes ☐ No
Please describe:	
31. **Impulse control:**	
Do they think before speaking/acting?	☐ Yes ☐ No
Are they accident prone?	☐ Yes ☐ No
Please give examples:	

32. SNAP -IV Teacher 18-Item Rating Scale, James M. Swanson PhD
For each item, check the column which best describes this child/ young person:

	Not at all	Just a little	Quite a bit	Very much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
10. Often fidgets with hands or feet or squirms in seat				
11. Often leaves seat in classroom or in other situations in which remaining seated is expected				
12. Often runs about or climbs excessively in situations in which it is inappropriate				
13. Often has difficulty playing or engaging in leisure activities quietly				
14. Often is “on the go” or often acts as if “driven by a motor”				
15. Often talks excessively				
16. Often blurts out answers before questions have been completed				
17. Often has difficulty awaiting turn				
18. Often interrupts or intrudes on others (e.g., butts into conversations/ games)				

FEEDBACK

We are currently updating the referral process for these assessments and would appreciate your feedback on this form. For example, is there any additional information that should be requested? Is there any wording you find confusing? Were you able to tell us everything you needed to about the child / young person? Do you have any other suggested improvements?

Thank you for taking the time to complete this referral. Please return all three sections of this form, with any supporting documents (e.g. reports), to the GP practice. GP practices: please refer via e-RS, or send the completed form securely to privatetherapy.clinic@nhs.net.