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. Please check our eligibility criteria before completing this form:

You are a Paediatrician referring to this clinic	❑ Yes
The child lives within the Northern catchment area	❑ Yes
The child has not yet turned 7 years of age	❑ Yes
The child has Medicare and items for ASD assessment have not been claimed before	❑ Yes
There is diagnostic uncertainty and a differential diagnosis needs to be considered by a team	❑ Yes
You have Audiology results, a comprehensive Paediatrician report/letter and an allied health report/letter (e.g. speech pathologist or key worker)	❑ Yes

For more information see: https://www.nh.org.au/service/autism-spectrum-disorder-assessment-clinic-2/

If you wish to discuss a referral's eligibility please call 8338 3000 or email NASDAC@nh.org.au

❑ 3 points of ID checked		
Date of Referral:	_____/_____/_____	Date of Birth: _____/_____/_____
Child's Name:	❑ Male ❑ Female ❑ Other: _____	
Address:		
Child's language(s):	❑ English ❑ Other:	Interpreter required: ❑ Yes ❑ No
Caregiver / Parent 1:	Name:	Relationship:
	Address:	Phone:
	Language(s): ❑ English ❑ Other:	Interpreter required: ❑ Yes ❑ No
	Email:	
Caregiver / Parent 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?		❑ No ❑ Yes
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? ❑ No ❑ Yes:

Comment:

NORTHERN HEALTH

NORTHERN AUTISM SPECTRUM DISORDER ASSESSMENT CLINIC REFERRAL

035006

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: _____

What is the reason for a multi-disciplinary team assessment? What is your differential diagnosis?

Area(s) of concern (please tick):

❑ Communication	❑ Language	❑ Speech	❑ Social & Interaction Skills
❑ Physical /Motor Skills	❑ Behaviour	❑ Attention	❑ Learning
❑ Feeding Skills	❑ Self-care skills	❑ Play skills	❑ Nutrition / diet / growth
❑ Atypical sensory responses	❑ Other:		

Please provide details:

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: The child must have already had a hearing assessment at time of referral	
Vision	❑ No ❑ Referred / awaiting. Service: _____ ❑ Yes. Service: _____	Normal results: ❑ Yes ❑ No Date: ___/___/___

Other Professionals Involved:

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

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: _____

Therapist/s (e.g. Community Health or private)	❑ 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:
Year child is planned to commence school:		

Please return this form to: **Community Access Service (CAS)**

Fax: 8405 8616 Phone: 9495 3443

Checklist – *Attach Audiology results, Allied Health report and Paediatrician report with this form*	
Audiology assessment report	❑ Yes
Allied Health Letter/Report/Assessment (e.g. key worker letter, language assessment or cognitive assessment)	❑ Yes
Paediatrician letter/report	❑ Yes
Investigations	❑ Yes ❑ N/A
Other:	❑ Yes ❑ N/A

Referrer Details:

Name: _____ Signature: _____

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

Provider Number: _____ Agency/Service: _____

Phone: _____ Email: _____

Postal Address: _____

NORTHERN AUTISM SPECTRUM DISORDER ASSESSMENT CLINIC REFERRAL

035006

NORTHERN HEALTH