**SOCIAL COMMUNICATION PATHWAY (SCP)**

**PARENT REFERRAL FORM**

Please return this form to:

South team: mft.south.scp@nhs.net

Central team: mft.centralmanchesterscp@nhs.net

North team: mft.northmanchesterscp@nhs.net

**The Social Communication Pathway is an assessment service for children and young people who might be autistic. No intervention is provided by this pathway.**

Child/Young Person’s Name:

Date of Birth:

Ethnicity:

Address:

School/Nursery/Child Minder:

Year Group:

Your Name:

Relationship to child:

Telephone number:

Email address:

Address:

GP Name:

Address:

Does this child have English as an additional language? **YES/NO**

If yes, what is their first language?

If yes, please comment on their level of English acquisition:

Is there any risk that your child is harming themselves or other people? **YES/NO**

Further details:

**If your child is self-harming/having suicidal thoughts, you need to also contact CAMHS – details at the end of this form**

Does your child have an autistic parent or sibling?

Has your child lost any skills that they previously had, e.g. had some words and now does not speak?

How long has your child been in school/nursery?

Has your child been assessed for autism before? Please give details:

**CONSENT**

I agree to refer my child for assessment of their social communication needs **YES/NO**

I agree to this information being shared with health and education professionals in order to help in the assessment of my child **YES/NO**

I agree to professionals in the Social Communication Pathway sharing information that might be held on my child’s health record **YES/NO**

I agree that information from any educational psychology assessments can be shared with health professionals on the pathway team **YES/NO**

I agree that child health records may be accessed by professionals in order to help in the assessment of my child **YES/NO**

**Please let us know who is requesting this assessment?**

**Are you filling in the form yourself?**

**If not, please provide the name of the person filling in this form:**

**Parental consent: Date:**

**If you do not have an electronic signature, please write your name in the space provided. We will accept this as your consent.**

**Please note that older children and young people will also need to consent to an assessment.**

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| What other professionals/services know your child? e.g., speech therapy/social worker/education psychologist |

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| --- |
| Please list the five main reasons you think you child needs an autism assessment1.2.3.4.5. |
| When did you first observe these signs? |

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| --- |
| What are your child’s strengths? |

|  |
| --- |
| Is there anything else we should know? For example, any recent life events that may have impacted your child? Does your child have any specific diagnoses? E.g., Cerebral Palsy or Down Syndrome? |

The Social Communication Pathway is for children and young people for whom an assessment of autism is indicated

If we feel that this child or young person would be better supported by another team, we may refer your child or young person to a more appropriate service. For example, if we feel the right support would be from a team specialising in developmental language, learning needs, co-ordination, or differences with attention and concentration we would signpost you to the right team.

We will write to you and your GP to explain our decision.

**Mental health teams**

South Manchester CAMHS: Carol Kendrick Centre 0161 902 3400

Central Manchester CAMHS: Winnicott Centre 0161 701 6880

North Manchester CAMHS: The Bridge 0161 203 3250

Please note that CAMHS teams are open Monday to Friday, 9am – 5pm (excluding bank holidays). If you have serious concerns about a young person’s immediate safety due to their mental health, please utilise the emergency services or A&E.

For support with emotional health and well-being please look at resources on the M-Thrive website where you can self-access the team <https://m-thrive.org/>