**SOCIAL COMMUNICATION PATHWAY (SCP)**

**SCHOOL REFERRAL FORM**

Please return this form to:

South team: [mft.south.scp@nhs.net](mailto:mft.south.scp@nhs.net)

Central team: [mft.centralmanchesterscp@nhs.net](mailto:mft.centralmanchesterscp@nhs.net)

North team: [mft.northmanchesterscp@nhs.net](mailto: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.

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?

**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 signature: Date:**

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

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**

Child/Young Person’s Name:

Date of Birth:

Address:

School:

Year Group:

Your Name and role:

Your telephone number:

Your email address:

Address:

Parent’s name:

Parent’s telephone number:

Parent’s email address:

|  |  |
| --- | --- |
| Is there any risk that the child/young person is harming themselves or other people? **YES/NO**  Further details:  **If the child/young person is self-harming/having suicidal thoughts, you need to also contact CAMHS – details at the end of this form** | |
| 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: |

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| Which other professionals/services have been involved with this child? E.g., speech therapy/social worker/education psychologist. Please provide details: |

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| **School information**  Is the young person registered as having SEND support needs? **YES/NO**  Please provide details and any relevant reports:  Has the child attended any other schools? Please provide details:  Has the child received any fixed term or permanent exclusions? Please provide details:  What adaptations are made in school: |

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| --- | --- | --- | --- | --- | --- |
| Academic performance compared to expected level for year group | Well below expected level | Somewhat below expected level | At expected level for | Above expected level | Well above expected level |
| English – writing |  |  |  |  |  |
| English – reading |  |  |  |  |  |
| English speaking and listening |  |  |  |  |  |
| Maths |  |  |  |  |  |
| Science |  |  |  |  |  |
| Attendance % | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Classroom performance | Severe cause for concern | Moderate cause for concern | Mild cause for concern | No cause for concern | Exemplary |
| Following directions/ instructions |  |  |  |  |  |
| Organisational skills |  |  |  |  |  |
| Assignment completion |  |  |  |  |  |
| Peer relationships |  |  |  |  |  |
| Complying with rules |  |  |  |  |  |
| Accepting boundaries |  |  |  |  |  |
| Independence/ self help skills for age |  |  |  |  |  |
| Fine motor skills |  |  |  |  |  |
| Gross motor skills |  |  |  |  |  |
| Further detail/examples of those scored severe or moderate concern | | | | | |

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| Please list the five main reasons you think this child/young person needs an autism assessment.  1.  2.  3.  4.  5. |
| When did you first observe these signs? |

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| What are their strengths? |

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

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| --- | --- | --- | --- |
| Please provide details of 2 cycles of SENCO led plan-do-review completed in school. | | | |
| Assess | Plan | Do | Review |
|  |  |  |  |
|  |  |  |  |

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 them 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 to the right team.

We will write to the family and 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 young people and families can self-access the team

<https://m-thrive.org/>