**Request for the Knowsley Neurodevelopmental Pathway (NDP)**

**Guidance for General Practitioners**

**Who is this form for?**

For professionals to refer children and young people for an assessment of Autism Spectrum Disorders (ASD) and/or Attention Deficit Hyperactivity Disorder (ADHD).

**Eligibility**

* ASD referrals for children as young as 3 can be accepted, but early years children should be reviewed by the Child Development Team first. If the child is in Reception or below and is not known to the Child Development Team, please refer to them first. For more information on this, please visit: <https://www.knowsleyinfo.co.uk/content/child-development-team>.

* Young people aged 18 and above will not be accepted and need to be referred to adult services.

* ADHD referrals for children under 5 will not be accepted.

* If urgent support or treatment is needed for a child in crisis, a referral to the NDP is not appropriate. If your concern is regarding mental health, please contact CAMHS Duty. Or, if this is a physical or mental health related emergency, please call 999 or go to A&E.

**How do I make a referral?**

Referrals can be made by completing this form with any relevant attachments and sending via email to [Knowsley.NDP@nhs.net](mailto:Knowsley.NDP@nhs.net). If you need help with this form, please contact the Knowsley Referral Management Service at Clinical Partners on **0203 905 9390.**

**How do I complete this form?**

We understand that this form might be difficult to complete in a short appointment, particularly when you may not know your patient well.

To make things easier, we've provided a checklist to fill out with the parent/carer. Please complete this as best you can, and attach any other relevant notes, such as your last consultation and any important medical information.

Please note that referrals with incomplete or insufficient information will be returned and can delay the child/young person being accepted onto the NDP.

**For GP to complete:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Referral:** | | | | |
| **Child’s Details:** | | | | |
| Name: |  | | | |
| Date of Birth: |  | Gender: |  | |
| NHS number: |  | | | |
| Address: |  | | | |
| School/Nursery Name: |  | | | |
| Ethnicity:    Please tick or circle | White/White British    Black/Black British    Asian/Asian British    Mixed    Other ethnic group, please describe:    Would prefer not to say | | | |
| First Language: |  | Interpreter needed? | Yes          No | |
| Disability/Medical needs? | Yes          No  If Yes, please provide detail: | | | |
| Adopted? | Yes          No                                Year Adopted: | | | |
| Looked After Child? | Yes          No                                Name of Social Worker: | | | |
| Child Protection Plan? | Yes          No                                Name of Social Worker: | | | |
| Child in Need? | Yes          No                                Name of Social Worker: | | | |
| Early Help? | Yes          No | | | |
| Education Health and Care Plan? | Yes          No | | | |
| Returner to the pathway? | Yes          No | Date previously referred: |  | |
| **Parent/Carer Details:** | | | | |
| Name: |  | Relationship to child: |  | |
| Address (if different to child): |  | | | |
| Mobile: |  | Home/Alternative phone: |  | |
| Email: |  | | | |
| Interpreted needed? |  | Language: |  | |
|  | | | | |
| Name: |  | Relationship to child: |  | |
| Address (if different to child): |  | | | |
| Mobile: |  | Home/Alternative phone: |  | |
| Email: |  | | | |
| Interpreter needed? |  | Language: |  | |
| **Parent/Carer Consent:**  Has parent/carer consented to share their details and their child’s details with the ND Pathway?  Please tick:   **Tick Box**  Has parent consented to the ND pathway contacting and sharing information with their GP, their child’s school and other professionals involved in their care?   Please tick:  **Tick Box**  Note: Consent must be given before you refer. | | | | |
| **GP/Referrer Details:** | | | | |
| GP Name: |  | Surgery: | |  |
| Address: |  | | | |
| Phone: |  | Email: | |  |

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| --- |
| **Reason for Referral:** |
| Concerns regarding the possibility of: (tick as appropriate)    Attention Deficit Hyperactivity Disorder (ADHD) ☐                Autism Spectrum Disorders (ASD) ☐ |
| **Briefly explain your reasons for making this referral.**  Please complete checklist below to provide more detail. |

|  |  |  |
| --- | --- | --- |
| **Checklist – please complete with parent/carer:** | | Please tick: |
| ASD | | |
| Social Communication | An odd or flat way of speaking | **Tick Box** |
| Lack of eye contact or expressions | **Tick Box** |
| Uses few or no gestures | **Tick Box** |
| Saying or doing things that can seem rude or inappropriate | **Tick Box** |
| Taking things literally | **Tick Box** |
| Struggles to make friends, or has few close friends | **Tick Box** |
| Lack of interest in talking or playing with others | **Tick Box** |
| Repetitive or Restricted Behaviour | Repetitive movements e.g., hand flapping, spinning, rocking | **Tick Box** |
| Unusual or repetitive play | **Tick Box** |
| Repeats words or phrases over and over | **Tick Box** |
| Strict routines, struggles with change | **Tick Box** |
| Fixated interests | **Tick Box** |
| Restricted diet e.g., will only eat certain foods | **Tick Box** |
| Avoids or dislikes certain sensations e.g., light, texture, noise, clothes | **Tick Box** |
| Seeks out certain sensations, e.g., likes to touch certain textures | **Tick Box** |
| ADHD | | |
| Inattention | Difficulty concentrating | **Tick Box** |
| Difficulty listening, or following instructions | **Tick Box** |
| Disorganised e.g., poor time management | **Tick Box** |
| Forgetful e.g., frequently losing items | **Tick Box** |
| Impulsivity | Acts without thinking | **Tick Box** |
| Interrupts others, or has trouble waiting their turn | **Tick Box** |
| Emotional outbursts, or quick to anger | **Tick Box** |
| Hyperactivity | Always ‘on the go’, moving or fidgeting | **Tick Box** |
| Unable to relax | **Tick Box** |
| Talks excessively | **Tick Box** |
| Any other details: | | |

Please attach your notes from your last consultation for this child, and any relevant medical records (including Paediatrics, Occupational Therapy, Speech and Language, CAMHS, Psychology).

Thank you for completing this form.