DERBYSHIRE County Council

Derbyshire Autism Outreach Service Referral Form

Behaviour Support and Autism Outreach are part of the same wider service.
Please only refer to one service at a time.

Personal Details:

Name of Pupil:	
Date of Birth:	
Year Group:	
School:	
Name and role of staff member completing form:	
Staff contact number:	
Staff email address:	
Date form completed:	
Gender:	**Male** ◯ **Female** ◯ **Other** ◯

Autism diagnosis?	
Date of diagnosis?	
By who?	
Evidence Attached?	**Y** ☐ Referrals will not be accepted without a diagnosis. Upload separately a copy of the autism diagnosis renaming the filename to: **830nnnn_AUTISMfaosuzannbanksdyyyymmdd** (nnnn = School DfE Number)

SEND Code of Practice:	**None** ◯ **SEN Support** ◯ **EHCP** ◯

In receipt of additional funding?	**TAPS** ☐ **GRIP** ☐ **EYIF** ☐ **Inclusion Fund** ☐
Other (Please state):	

Attendance %:		**CIC?**	Please Select:
Part-time timetable?	Please Select:	**Pupil Premium?**	Please Select:
Number of Fixed Term Exclusions?		**Risk of Permanent Exclusion?**	Please Select:

Any other diagnosis?

Other Agencies Involved

Name:	Role/ Organisation:

Is the child or young person meeting age related expectations in the following areas?

Academic:	Please Select:	**Social Interaction:**	Please Select:
Behaviour:	Please Select:	**Engagement in Learning:**	Please Select:

About the child or young person:

Outline the **strengths and interests** of the child or young person and areas where progress have been made:

Autism Outreach provides support to **school staff** for the following areas of need:

- Anxiety / Emotional regulation
- Sensory processing
- Social understanding and communication
- Flexibility, information processing and understanding

Outline the **key areas of concern linked to the above:**

Please indicate if you have completed the following activities:	Please tick:
Used the Graduated Response document to improve provision.	
Identified an Autism Advocate within your setting who has accessed AET training.	
Carried out an Environmental Audit from the Derbyshire Sensory Processing Needs Toolkit.	
Created a Sensory Plan for this child using the Derbyshire Sensory Processing Needs Toolkit.	

What current **autism specific strategies** are in place to address the difficulties listed above?
(Please attach a provision map, if possible)

Please tell us about any **experience or training** staff in the school have had in relation to autism:

What are your **priority outcomes** for the child with the support for the **school** from Autism Outreach?

Parent Carer Permission

Any parent / carer concerns or comments?

Parental / carer permission for referral:	Yes ◯ No ◯
Which member of staff was permission given to?	
Name of parent / carer:	
Parent / carer signature:	

Only complete applications with evidence of diagnosis will be considered by the service. We may offer signposting to supportive resources, training or caseload work.

1. Rename the completed referral form as:

830XXXX_AUTISMfaosuzannbanksryyyymmdd (XXXX – school DFE number)

2. Upload separately a copy of the autism diagnosis renaming to:

830XXXX_AUTISMfaosuzannbanksdyyyymmdd

3. Upload to AO via school secure area on Derbyshire SchoolsNet Perspective Lite.

Any queries, please contact:
autism.outreach@derbyshire.gov.uk or call Suzann Banks, 01629 532512 (Mobile: 07500 127614)

For Office Use Only:

Date referral received:	
Date school notified receipt resumed referral:	
Date inputted on AO referral spreadsheet:	
PSS Number:	
PSS & E File:	