

Autism Enablement Referral Form



This referral is to provide a concise summary of the goals identified with the individual following an assessment of eligible needs under the Care Act (2014).

Please e-mail completed form to the Autism Referral Panel inbox:

enablement.autism@kent.gov.uk

Please ensure that it is clearly marked 'Autism Enablement Referral'.

Mosaic/LAS ref:		Date of referral:	
Individuals Name:			
Name of referrer and contact details:			

Has the individual consented to this referral?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Does the individual have any communication needs? <i>(e.g. verbal/non-verbal, hearing/visually impaired, lip reader, written, advocate or interpreter required?)</i>
How would the individual prefer to be contacted? <i>(e.g. Text, Email, Letter, phonecall)</i>

Details of all diagnoses <i>(including possible diagnoses)</i>

Which services are currently involved with the client? <i>(e.g. CMHT, Porchlight, Forward Trust etc.)</i>

Details of known risks associated with the individual or tasks <i>(Person, Environment, Task e.g. individuals allergies or risks to professionals etc.)</i>

Requested work/identified goals for referral <i>(that can be achieved within a 16 week intervention)</i>