

South East Essex Children’s Services Lighthouse Child Development Centre

Please return by email to: [**epunft.seechs.singlepointofaccess@nhs.net**](mailto:epunft.seechs.singlepointofaccess@nhs.net)

Telephone: **0344 257 3952**

**Screening Assessment Questionnaire Autism & ADHD Assessment: Parents or Carers**

**If you would like help filling out this form, please start by asking your child’s school or social worker. If this is not appropriate, please contact our team to support you.**

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| **Tick Box**   |  |  | | --- | --- | | By returning the completed form, **we assume that you as the parent or carer are consenting** to the referral being processed by Children’s Services. |  | |
| **Incomplete forms will delay the referral.** |

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| **CHILD’S DETAILS** | | | |
| **Name:** |  | | |
| **DOB:** |  | **NHS Number:** |  |
| **Address:** |  | | |
| **GP Details:** |  | | |
| **DETAILS OF PARENTS/ CARERS FILING IN THE FORM** | | | |
| **Name:** |  | | |
| **Address, if different:** |  | | |
| **Contact Number:** |  | | |
| **Email Address:** |  | | |

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| **Please summarise the main reason for your referral:** |
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| **Are there concerns at home/ at school or in both situations?** |
| Please describe |
| **How old was your child when you became concerned?** |
| Please describe |
| **In what way do you hope this assessment will help your child?** |
| Please describe |

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| **FAMILY HISTORY: Who is in your child’s close family?** | | | | | |
| **NAME** | **AGE** | **GENDER** | **RELATIONSHIP TO CHILD/ YOUNG PERSON** | | |
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| **Does any family member have any of the following conditions?** | | | | | |
| Neurological Disease | | | | YES | NO |
| Learning difficulties | | | | YES | NO |
| ADHD | | | | YES | NO |
| Autistic Spectrum Disorder | | | | YES | NO |
| Mental Health disorder/ concerns | | | | YES | NO |
| Other significant health issue | | | | YES | NO |
| If yes, please specify: | | | | | |
| **Developmental milestones (please detail if there was any delay or history of a loss of skill):** | | | | | |
| Please describe | | | | | |

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| **COMMUNICATION** |
| **Please describe any speech and language difficulty your child is experiencing now or has had in the past** |
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| **Please describe your child’s communication. Comment on who they communicate with, how they communicate, why they communicate – for example: to express their needs, to give information, to share experiences, to have a to and fro conversation, or ‘no concerns’.** |
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| **Please describe any difficulties that your child has with listening, responsiveness, understanding what you have said or following instructions** |
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| **SOCIAL INTERACTION** |
| **How does your child get on with other members of the family?** |
| Please describe |
| **How does your child get on with other children/young people?** |
| Please describe |
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| **PLAY AND IMAGINATION** |
| **What does your child like to play with or how do they spend their time?** |
| Please describe |
| **Does your child show – please tick all that apply:** |
| Unusual aspects to their play? |
| Lack of pretend play, limited imagination. |
| Comments: |
| **Please give details of any intense or unusual interests that your child may have:** |
| Please describe |
| **Please outline any routines that your child shows a strong preference for or has to follow:** |
| Please describe |
| **Does your child… – please tick all that apply:** |
| Engage in repetitive behaviours or rituals (doing the same thing in a certain way?) |
| Have difficulty with minor changes in routine? |
| Comments: |
| **SENSORY ISSUES** |
| **Is your child excessively sensitive to:** |
| Please describe |
| **Does your child show an unusual level of interest in :** |
| Please describe |
| **Please describe any sensory seeking behaviours that your child displays:** |
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| **MOTOR MANNERISMS** (Stimming or repetitive body movements) |
| Please describe |
| **Please outline any repetitive/unusual body movements that your child engages in:** |
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| **ATTENTION AND ACTIVITY LEVELS** |
| **Does your child often … ( please tick all that apply)** |
| blurt out answers/ not wait for questions to be finished |
| take actions without thinking of the consequences |
| act then instantly say they didn’t mean to |
| find it difficult to stay focussed on play or activities |
| disturb others when playing or working |
| make ‘careless mistakes’ or inaccuracies in school work |
| get out of their seat a lot, when not expected |
| climb and jump when being still is expected |
| fidget and squirm in their seat |
| act ‘on the go’ all of the time |
| avoid activities which require mental effort |
| not finish tasks (even ones they can easily do) |
| find it difficult to start tasks (even ones they could easily do) |

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| **BIRTH DETAILS** |
| **Did you have any health concerns, during your pregnancy?** |
| Please describe |
| **Did you take any medication during your pregnancy? (If so, what did you take?)** |
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| **How long was the pregnancy in weeks (full-term is 37 to 40 weeks).** |
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| **What was your child’s birth weight?** |
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| **Any history of post-natal depression?** |
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| **How was your child delivered and did they required any after birth care? Please tick all that apply:** | | | | | |
| Normal | | | | | |
| C-Section | | | | | |
| Ventouse/ Forceps | | | | | |
| Comments: | | | | | |
| **At or after delivery – please tick all that apply:** | | | | | |
| Resuscitation needed | | | | | |
| Admitted to special care | | | | | |
| Feeding difficulties | | | | | |
| Postnatal depression | | | | | |
| Comments: | | | | | |
| **EARLY DEVELOPMENT** | | | | | |
| **Were any of the following areas of your child’s development of concern to you after birth – please tick all that apply:** | | | | | |
| Gross motor skills – sitting, walking or running | | | | | |
| Any regression of gross motor skills | | | | | |
| Fine motor skills – picking up and handling toys or cutlery, drawing or cutting | | | | | |
| Language - What age did they speak words other than mama and dad? | | | | | |
| Any speech regression | | | | | |
| Hearing | | | | | |
| Eyesight | | | | | |
| Self-help skills – dressing, feeding, toileting | | | | | |
| Play skills | | | | | |
| Imaginative or pretend play skills – copying household activities, dressing up  or playing with dolls or teddies or small world toys | | | | | |
| Aggressive or irritable behaviour | | | | | |
| Loss of any skills that they previously had | | | | | |
| **Please outline any concerns about early development** **here:** | | | | | |
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| **EDUCATION** | | | | | |
| **Name of the preschool/nursery or school attended. Please write home schooled stating the reasons why the child is/was home schooled if applicable.** | | | | | |
| Please describe | | | | | |
| **Please describe difficulties the child experienced during their preschool, nursery or primary or secondary school years as applicable? (Bullying, running away from school, social isolation, poor school attendance, exclusions etc.)** | | | | | |
| Please describe | | | | | |
| **Please describe any extra support the child received at preschool nursery, primary or secondary school:** | | | | | |
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| **MENTAL AND EMOTIONAL WELL-BEING** | | | | | |
| **Please tick against any concerns you have about your child’s emotional well-being:** | | | | | |
| Anxiety | Fears or phobias | | Obsessive Compulsive Behaviours | | |
| Hyperactivity | Hallucinations | | School attendance issuess | | |
| Mood Swings | Eating Disorder | | Anger or aggression | | |
| Low Mood | Suicidal Ideation | | Domestic Violence | | |
| Bereavement | Self-Harm | | Drug or Alcohol use or addiction | | |
| Impulsivity | Short Attention span | | Criminal activity/ antisocial  behaviours and or Involvement with Youth Offending Team | | |
| **Has your child ever had treatment (including hospitalisation) by, or is currently seeing, a psychiatrist, psychologist, therapist, or counsellor?** | | | | YES | NO |
| **If yes, please give the following details: Nature of the concerns; start and end date of support; where seen and clinician’s name; type of support, for example: counselling, play therapy, cognitive behaviour therapy, group work, family work, parent support and advice.** | | | | | |
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| **PREVIOUS ASSESSMENTS** | | | | | |
| **Please indicate if your child has had any of the following assessments? Please attach copies of any reports and information on support provided** | | | | | |
| Paediatric developmental assessment | | Educational psychological assessment | | | |
| Clinical psychological assessment | | Speech and language assessment | | | |
| CAMHS assessment | | Occupational Therapy assessment | | | |
| Children’s Centre | | Special Needs Health visitor | | | |
| Health visitor | | Early Years SEN team or Communication and Autism Team (advisory teachers) | | | |
| SEN Specialist Advice and Support Service | | School support including SENCO, TAC (Team Around the Child), parent support, counselling, circle of friends, social support, behaviour support, Pupil Support Base | | | |
| Social Services including CIN (Child in Need) and CP (Child Protection) | | CAMHS Step 2 and Specialist CAMHS | | | |
| Families First/ Intensive Family Support | | Angels/Add-vance/Space/other voluntary agency | | | |
| Other- Please specify (including in the NHS, Independent or charity sector): | | | | | |

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| **INFORMATION SHARING & CONSENT:** | | |
| **Information about your child may be shared with other teams and agencies (eg Education services, Children’s Centres and social care) in order to identify the most appropriate support for your child** | | |
| **Has the referral been discussed with the child or young person?** | YES | NO |
| **Is there parental consent for enquiry/onward referral to other agencies?** | YES | NO |
| **Is there parental consent to contact school?** | YES | NO |
| **Is there child consent to be contacted whilst at school?** | YES | NO |
| **Signed (Parent/Carer):** | **Date:** | |

**THANK YOU FOR COMPLETING THIS FORM**