

The Psychology Department
 2 Park Avenue
 Wood Green
 London N22 7EX
 Tel: 0203 3266 363

Email:
 psychology@hoffmannfoundation.org.uk

REFERRAL INFORMATION

DATE: _____

_____ Hoffmann Foundation for Autism Contact

Personal Information

Name of client

Date of Birth

Address / Telephone

Address:

Telephone:

Mobile:

Current living situation

Parental home Own home Supported living Residential home

Sex

Preferred language

Communication:

Does the person has language problems? Please specify e.g.: the client understands a few words or signs/or both.

Verbal

Signs

Non-verbal

Few words



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REFERRAL INFORMATION

Person making referral:
Contact details of referrer: _____
Relationship to Client:

Reason for Referral

Is Client aware of/given consent for referral (circle one): Y N

Family/ Carer Information/Next of kin

Address / Telephone of Parent – Guardian / Carer

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Other Contacts (Include relationship to Client)

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Please describe any difficult behaviours such as i.e: physical aggression, obsessions, verbal abuse, difficulty in communication?

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NATURE OF DISABILITY

Comments:

- Communication Difficulty
- Autism
- Aspergers Syndrome
- Learning Difficulty
- Physical Disability
- Other (please specify)

If Client was diagnosed Autism Spectrum Disorder (ASD) / Aspergers Syndrome:

Date of diagnosis:

Name of clinician: _____
Address / Telephone:

If Client is NOT diagnosed ASD – Do they display Autistic tendencies?

Please describe. i.e social , communication problems, obsessive behaviours or rituals

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Name of Client:

What are the specific needs of this client?

SERVICE REQUEST

- Residential
- Supported Living
- Respite
- Counselling
- HUB Services
- Outreach
- Social Skills Group
- Counselling
- Diagnostic assessments

Comments



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Other (please specify)

FUNDING INFORMATION

Funding Authority:

Social Care Manager:

Address / Telephone/e-mail:

GP's Name:

Post address:

Tel/email: