Hoffmann Foundation for autism
Founded by Alice Hoffmann de Visme

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

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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Brief account of client's history to date (inc. schools, services, medical, accommodation and employment).

School:

Previous Services/ accommodation:

Medical:

Employment:

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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

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

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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: