**Western Bay Integrated Autism Service (IAS)**

**Request form for Support**

*This form can be completed by you or you could ask a family member, friend or a professional such as a GP to complete it with you or on your behalf.*

NB. It is a requirement of the service that you provide documentation confirming your diagnosis of Autism or of the person you are requesting support for.

**Details of person seeking support**

|  |  |
| --- | --- |
| **Date of request** |  |
| **Name** |  |
| **Preferred name** |  |
| **Date of birth** |  |
| **Sex** |  |
| **Gender at birth** |  |
| **Ethnicity** |  |
| **Culturally important information** |  |
| **Address** |  |
| **Telephone numbers** |  |
| **Email address** |  |
| **Preferred language** |  |
| **Preferred method of contact** | Eg, phone, email or letter? |
| **Other services currently involved** |  |

**Details of person completing this form (if different from above)**

|  |  |
| --- | --- |
| **Surname** |  |
| **Forenames** |  |
| **Address** |  |
| **Telephone numbers** |  |
| **Email address** |  |
| **Relationship to the person seeking support** |  |
| **Have you discussed the request and received the person’s consent to complete this form? If this is regarding parent/carer support of a child, do you have the consent of the parents/care givers?** |  |
| **Age of Parent/Carer** |  |
| **Gender of Parent/Carer** |  |
| **Ethnicity of Parent/Carer** |  |
| **Employment status of Parent/Carer** |  |

**GP Details**

|  |  |
| --- | --- |
| **Name** |  |
| **GP Practice address** |  |
| **Telephone number** |  |

**School/College/Employment details (if relevant)**

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| **Are you, or the person you are referring, currently being supported by any of the services below? (tick all that apply)** | | | |
| Adult Learning Disability |  | CAMHS |  |
| Community Mental Health |  | Education |  |
| Social Services |  | Third Sector |  |
| Primary Mental Health |  | Health Visiting/School Health Nursing |  |
| Neurodevelopmental (NDD) Service |  | TAF/EVOLVE |  |
| Children’s Disability Team |  | Forensics Services |  |
| Adult Complex Disabilities Service |  | Other: |  |
| Please give details of involvement: | | | |

|  |
| --- |
| **Reason for referral** |
| What outcome do you want the Integrated Autism Service to help you with? |

|  |
| --- |
| **Please tell us what is working well** |
|  |
| **Please tell us what is not working well** |
|  |

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| **Please provide additional information including known risks eg, alcohol, prescription drugs, non-prescription drug dependency, suicidal thoughts and/or safeguarding concerns.** |
|  |

**Request information**

**NB. It is a requirement of the service that you provide documentation confirming diagnosis of Autism with this request.**

**Please return to:**

Western Bay Integrated Autism Service (IAS)

Tonna Hospital

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SA11 3LX

Telephone: 01639 862936

Email: SBU.WBIAS@wales.nhs.uk