

**Screening Questionnaire - Neurodevelopmental Assessment, Autism & ADHD**

**Parents/Carers or Young Person**

**If you would like help filling out this form, please start by asking [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 completing this form, **we assume that you are consenting** to the referral being processed by children’s Services. |  | |
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| **CHILD’S DETAILS –** | | | | | |
| **\*Name:** |  | | | | |
| **\*DOB:** |  | **\*NHS Number:** |  | | |
| **\*Sex:** |  | | | | |
| **\*Address:** |  | | | | |
| **\*GP Details:** |  | | | | |
| **DETAILS OF PARENTS/ CARERS FILING IN THE FORM –** | | | | | |
| **\*Name:** |  | | | | |
| **\*Address, if different:** |  | | | | |
| **\*Contact Number:** |  | | | | |
| **\*Email Address:** |  | | | | |
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| **Is [Child’s] gender the same as the sex they were registered at birth?** | | | | Yes | No |
| **How does [Child] like to be addressed and what pronouns are preferred?** | | | | | |
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| **\*Please summarise your main concerns** |
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| **\*Are there concerns at home/ at school or in both situations?** |
| Please describe |
| **\*How old was [Child] when you became concerned?** |
| Please describe |
| **\*In what way do you hope this assessment will help [Child]?** |
| Please describe |
| **Is there a previous diagnosis we should be aware of? (including ones done privately)** |
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| **FAMILY HISTORY: Who is in [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 |
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| \*Please provide more detail | | | | | |
| **\*Were any of the following areas of [Child]’s development of concern after birth – please tick all that apply** | | | | | | |
| Skills such as sitting walking or running | | | | | | |
| Skills such as picking up and handling toys, cutlery, drawing or cutting | | | | | | |
| Speech regression (Was there a time when [Child] spoke more or better than they currently do?) | | | | | | |
| Dressing and toileting | | | | | | |
| Hearing | | | | | | |
| Eyesight | | | | | | |
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| **Please comment on any concerns about early development and let us know if there was any delay or history of a loss of skill such as talking, sitting or walking** | | | | | | |

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| **COMMUNICATION** |
| **\*Please describe any speech and language difficulty [Child] is experiencing now or has had in the past** |
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| **\*Please describe [Child]’s communication. Comment on who, how and why they communicate – for example: to express needs, to give information, to share experiences, to have a to and fro conversation.**  **If [Child] is non-speaking, please state what methods they do use.** |
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| **\*Please describe how [Child] responds to instructions and if you have any concerns around their listening.** |
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| **\*Please describe how [Child] uses non-verbal communication. For example – gestures, eye contact, facial expressions, tone of voice.** |
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| **SOCIAL INTERACTION** |
| **\*How does [Child] get on with other members of the family? (e.g. sharing interests, understanding feelings of others)** |
| Please describe |
| **\*How does [Child] get on with other children/young people? (e.g. making and keeping friends, showing concerns for others and their feelings)** |
| Please describe |
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| **PLAY AND IMAGINATION** |
| **\*What does [Child] like to play with or how do they spend their time?** |
| Please describe |
| **\*Does [Child]:** |

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| Play with toys in the way they are intended | YES | NO |
| Use pretend and imaginary play (e.g. playing a role like a teacher, feeding a baby or a parent cooking etc) | YES | NO |

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| Please describe: | | |
| **\*Has [Child] got any focussed interests** | **Yes** | **No** |
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| Please give details of any focussed interests that [Child] may have: | | |
| **\*Please outline any routines that [Child] shows a strong preference for or has to follow:** | | |
| Please describe | | |
| **\*Does [Child]:** | | |

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| Engage in repetitive behaviours or rituals (doing the same thing in a certain way?) | YES | NO |
| Cope with minor changes in routine? | YES | NO |

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| Please describe: | | |
| **SENSORY** | | |
| **\*Have you got concerns about how [Child] responds to noise?** | **Yes** | **No** |
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| Please describe how [Child] responds to noise (E.g. covers ears; slow to respond when you speak to them; gets easily distracted; gets distressed, makes loud noises or hums) | | |
| **\*Have you got concerns about how [Child] responds to touch?** | **Yes** | **No** |
| Please describe how [Child] responds to touch (E.g. dislikes messy play; has difficulty touching or wearing certain materials; reacts in unexpected ways when someone touches them) | | |
| **\*Have you got concerns about how [Child] responds to movement?** | **Yes** | **No** |
|  | | |
| Please describe how [Child] responds to movement (E.g. flaps hands and enjoys it; dislikes swings and slides; difficulty climbing steps; often fidgets or bounces, walks on tiptoes) | | |
| **\*Have you got concerns about how [Child] responds to taste or smell?** | **Yes** | **No** |
|  | | |
| Please describe how [Child] responds to taste and smell (E.g. avoids certain tastes, textures or smells; eats a small range of food; prefers food with bold textures and flavours) | | |
| **\*Have you got concerns about how [Child] responds to light?** | **Yes** | **No** |
|  | | |
| Please describe how [Child] responds to light (E.g. enjoys looking at things move, enjoys moving or flickering light, avoids or is distressed by bright lights) | | |
| **Is [Child] able to recognise and label feelings in their body?** | | |
| Please describe if [Child] knows when / if they are hot/cold hungry / tired / needing to toilet etc | | |
| **Please describe any other sensory seeking behaviours that [Child] enjoys:** | | |
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| **Please describe any other sensory avoiding behaviours [Child] shows:** | | |
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| **MOTOR MANNERISMS** (Stimming or repetitive body movements) |
| **Please outline any repetitive/unusual body movements that [Child] engages in (e.g walks on their tiptoes or in an unusual way; likes to spin around more than other children; flaps their hands; bounces on their feet when excited; staring blankly at objects, collecting unusual items; attachment to objects):** |
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| **ATTENTION AND ACTIVITY LEVELS** |

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| **\*Does [Child]:** | **Never** | **Sometimes** | **Always** | **N/A** |
| Is enthusiastic and keen to share their ideas before the speaker has finished asking a question |  |  |  |  |
| Is overbearing and loud while playing with peers |  |  |  |  |
| Takes actions without thinking of the consequences |  |  |  |  |
| Acts then instantly says they didn’t mean to |  |  |  |  |
| Difficulty staying on task in the class or in play |  |  |  |  |
| Disturbs others when playing or working |  |  |  |  |
| Has ‘careless mistakes’ or inaccuracies in work |  |  |  |  |
| Gets out of their seat when not expected |  |  |  |  |
| Climbs and jumps when being still is expected |  |  |  |  |
| Fidgets and squirms |  |  |  |  |
| Is always ‘on the go’ |  |  |  |  |
| Difficulty listening to teaching part of lesson/ assembly |  |  |  |  |
| Avoids or dislikes activities which require mental effort |  |  |  |  |
| Doesn’t finish tasks |  |  |  |  |
| Finds it difficult to start tasks (even ones they could easily do) |  |  |  |  |
| Is forgetful during tasks |  |  |  |  |
| Often loses items |  |  |  |  |
| Can not get organised with equipment needed |  |  |  |  |
| **Any comments you would like to add with respect to the attention and activity levels above?** | | | | |
| Please add information such as zoning out, experiencing difficulties with making a choice, finding it difficult to prioritise tasks, forgetting to eat/drink | | | | |

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| **BIRTH DETAILS** |

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| **\*Were there any concerns about mum’s health during the pregnancy?** | **Yes** | **No** | **Not sure** |

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| Please describe |

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| **\* Did mum take any medication during the pregnancy?** | **Yes** | **No** | **Not sure** |

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| **What medication was taken?** | | |
| **\*How long was the pregnancy in weeks (full-term is 37 to 40 weeks).** | | |
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| **\*Do you know [Child]’s** **birth weight?** | Yes | No |
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| **What was [Child]’s birth weight?** | | |
| **\* Any history of post-natal depression?** | **Yes** | **No** |

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| **\*How was [Child] delivered? Please tick any that apply:** | | | | | |
| Unassisted vaginal birth | | | | | |
| C-Section | | | | | |
| Ventouse/ Forceps | | | | | |
| Not sure | | | | | |
| Comments: | | | | | |
| **\*Did [Child] require any after birth care at or after delivery? please tick all that apply:** | | | | | |
| Resuscitation needed | | | | | |
| Admitted to special care | | | | | |
| Feeding difficulties | | | | | |
| Not sure | | | | | |
| None | | | | | |
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| Comments: | | | | | |
| **EDUCATION** | | | | | |
| **\* Name of Preschool/nursery or education setting attended (state if the CYP is home educated)** | | | | | |
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| **Please describe difficulties [Child] experienced during their preschool, nursery or primary or secondary school years if applicable? (Bullying, running away from school, social isolation, school attendance difficulties, exclusions etc.)** | | | | | |
| Please describe | | | | | |
| **\*Please describe any extra support [Child] received or is receiving at preschool nursery, primary or secondary school:** | | | | | |
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| **MENTAL AND EMOTIONAL WELL-BEING** | | | | | |
| **\*Please tick against any concerns you have about [Child]’s emotional well-being:** | | | | | |
| Anxiety | Fears or phobias | | Obsessive Compulsive Behaviours | | |
| Hyperactivity | Hallucinations | | School attendance difficulties | | |
| 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 | | |
| **Would you like to elaborate on areas you ticked?** | | | | | |
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| **\*Has [Child] ever had treatment (including hospitalisation) by, or is currently seeing, a psychiatrist, psychologist, therapist, or counsellor?** | | | | YES | NO |
|  | | | | | |
| **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.** | | | | | |
| **PREVIOUS ASSESSMENTS** | | | | | |
| **\*Please indicate if [Child] has had any of the following assessments? Please attach copies of any reports and information on support provided if available** | | | | | |
| 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 [Child] may be shared with other teams and agencies (e.g. Education services, Children’s Centres and social care) in order to identify the most appropriate support.** | | |
| **\*Does the parent/carer consent to this referral** | YES | NO |
| **\*Does [Child] consent to this referral** | YES | NO |
|  | | |
| **Please explain why (e.g. non-speaking, [Child] lacks mental capacity and/or is not at an age where this is appropriate)** | | |
| **\*Is there consent for enquiry/onward referral to other agencies?** | YES | NO |
| **\*Is there consent to contact school?** | YES | NO |
| **\*Is there consent to contact [Child] whilst at school?** | YES | NO |

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| **\*Who completed this form?** | **Parent/Carer** | **[Child]** | **Parent/Carer and [Child] together** |

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| **\*Signed:** | **\*Date:** |