Right to Choose

Neurodevelopmental lifespan services

Autism spectrum disorder (ASD) assessment report

**REPORT DETAILS**

| Assessment date(s) | ##/##/####  ##/##/#### |
| --- | --- |
| Report date | ##/##/#### |
| Clinical team | YYY (Community Paediatrician)  YYY (Child & Adolescent Psychiatrist)  YYY (Clinical Psychologist)  YYY (Speech & Language Therapist)  YYY (Occupational Therapist) |
| Report sent to: | Parent/Carer |
| GP |
| If applicable and consent sought, clinician to add any other name/email here for report to be sent to (e.g. social worker) |

This report aims to provide greater understanding of XXX’s experiences, strengths, and challenges, and to explore whether a diagnosis may help explain their unique profile. It is based on the information available at the time of the assessment. This assessment was not conducted for medico-legal purposes and, as such, is not intended for use in that context.

**CLIENT DETAILS**

| First name | XXX |
| --- | --- |
| Surname | QQQQ |
| Age at assessment | QQ y QQ m |
| Date of birth | ##/##/#### |
| NHS number | QQQQ |
| Client ID | QQQQ |
| Address | QQQQ |

**ASSESSMENT OUTCOME**

{{Assessment\_Outcome}}

*(Diagnosed)*

We have carefully considered all the information and reports for XXX and watched them interacting with their parent/carer and an assessor in an ADOS clinic. Our conclusion is that XXX’s unique patterns of thinking and behaviour are best understood in relation to autism.

The features we have identified together meet the DSM-5 criteria for a diagnosis of autism (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, APA, 2013.). These criteria describe persistent differences in social communication and interaction, alongside patterns of restricted and repetitive behaviours, interests, or activities, present from early development and impacting daily life. It is also necessary to confirm that these experiences are not better explained by another condition.

**It is our joint opinion that XXX meets criteria for autism.** Our analysis of this is presented below.

People often prefer to use the term ‘difference’ rather than ‘disorder’ and XXX’s parent/carer(s) may prefer to use this word when describing XXX’s distinct characteristics.

*(Not diagnosed)*

Our conclusion is that the unique characteristics displayed by XXX may resonate with aspects of autism, but do not align sufficiently for an autism diagnosis.

The features looked at come from the DSM-5 criteria for autism (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, APA, 2013). These criteria describe persistent differences in social communication and interaction, alongside patterns of restricted and repetitive behaviours, interests, or activities. These differences are present from early development and have a significant impact on day-to-day life. It is also necessary to confirm that these experiences are not better explained by another condition.

**It is our joint opinion that XXX does not meet criteria for autism**. Our analysis of this is presented below in this report. Although XXX has not received a formal diagnosis, this does not diminish the challenges they are experiencing. We fully acknowledge their difficulties and have provided recommendations for the next steps, which we hope will be helpful.

**ASSESSMENT INFORMATION**

{{Assessment\_Information}}

Psicon was commissioned to carry out an autism spectrum disorder (ASD) assessment.

The assessment offered by Psicon includes consideration of the child’s current functioning, developmental history information offered by parent/carer, a social communication observation and information provided by the school/nursery. All information is reviewed with the team’s input, before deciding the outcome and future plan.

Clinician to complete (select **one**)

* The assessment was carried out face-to-face. The developmental history information was collected from XXX’s mother/father/OTHER.
* The assessment was carried out via video consultation. The developmental history information was collected from XXX’s mother/father/OTHER.
* The social communication observation was carried out face-to-face, and the clinical interview was carried out via video consultation. The child was seen during the remote appointment. The developmental history information was collected from XXX’s mother/father/OTHER.

**WHO WE ASSESSED**

Positive connotation only – e.g. strengths, character, positive traits, likes/dislikes, special interests/passions, positive behaviour during the assessment process, positive family connections/relationships

{{Who\_We\_Assessed}}

**CONSENT**

{{Consent}}

Clinician to complete (select **one** of two)

* Parent/carer provided their consent for the assessment to take place.
* (Gillick competent) The structure of the session was explained to XXX and they confirmed they understood the purpose of the appointment and consented for the assessment to take place.

**UNDERSTANDING OF APPOINTMENT**

Include parent’s understanding of the appointment and expectations, include child’s understanding of the appointment (if age relevant)

{{Understanding\_of\_Appointment}}

**REASON FOR REFERRAL AND PRESENTING CONCERNS**

Include what and when were the first concerns; Include current concerns from parent/carer and school perspective; Include child’s perspective (if age relevant) e.g. how are things going at school for them

{{Reason\_for\_Referral\_and\_Presenting\_Concerns}}

**PAST MEDICAL HISTORY**

Include pregnancy, birth history, allergies, current medication, hearing, vision, hospital admissions, involvement with other specialist health services e.g. paediatric team, speech and language etc.

{{Past\_Medical\_History}}

**EARLY DEVELOPMENTAL HISTORY**

Include infant development, speech development, motor skills development, toilet training, play

{{Early\_Developmental\_History}}

**FAMILY AND SOCIAL HISTORY**

Include household details, mental and physical health of family members, significant life events, reference current or previous involvement with social care and/or Early Help

{{Family\_and\_Social\_History}}

**MENTAL HEALTH AND WELLBEING**

Include anxiety and mood, any prior or current mental health services input

{{Mental\_Health\_and\_Wellbeing}}

**CURRENT DEVELOPMENT AS REPORTED BY PARENT/GUARDIAN**

***Social Communication & Interaction***

Include social reciprocity, non-verbal communication and relationships, language and social skills

{{Problems\_with\_Social\_Initiation\_and\_Response}}

{{Problems\_with\_Nonverbal\_Communication}}

***Friendships & Relationships***

Include how others perceive the child, empathy and emotional intelligence

{{Problems\_with\_Social\_Awareness\_and\_Insight}}

***Restricted & Repetitive Behaviours and Interests/Activities***

Include repetitive behaviours, routines, resistance to change, special interests, sensory sensitivities

{{Atypical\_Speech\_Movements\_and\_Play}}

{{Rituals\_and\_Resistance\_to\_Change}}

{{Preoccupations\_with\_Objects\_or\_Topics}}

{{Atypical\_Sensory\_Behaviours}}

***Emotional & Behavioural Regulation***

Reference at home/in relationships/in primary school/in secondary school/in nursery or college (if applicable)

[type here]

***Attention***

Reference focus, hyperactivity, inattention, impulsivity, executive functioning

[type here]

***Self-Care & Independence***

Reference organisational independence and personal hygiene, eating and sleeping habits

[type here

**EDUCATION**

Include nursey, primary school, secondary school and college (if applicable), general academic performance, teacher feedback/summarise school report

[type here]

**AUTISM DIAGNOSTIC OBSERVATION SCHEDULE 2 (ADOS-2)**

The ADOS-2 is a semi-structured observational assessment where the participant interacts with an adult (examiner) across a range of activities such as telling a story from a book, conversation and reporting and make-believe play. The ADOS attempts to create a “social world” in which behaviours related to autism can be observed. This session was used to explore the young person’s communication and social interaction preferences, their use of social imagination and to comment on the level of structure required to support them in a novel social situation.

As well as focusing on identifying autistic features, the clinicians also make observations intended to highlight the young person’s strengths to provide meaningful insights into their individual needs.

The ADOS-2 is currently presented in five modules, each to be used according to the young person's age and level of verbal communication.

Insert ADOS report here

[here]

**OBSERVATIONS FROM CLINICAL INTERVIEW**

Include observations during clinical interview/developmental history (e.g. how they interacted with clinician during the session, their response to the session etc.)

Detail any physical features that may need follow up (e.g. dysmorphic facial features)

{{Observations\_from\_Clinical\_interview}}

**WHY DID WE DIAGNOSE? / WHY DID WE NOT DIAGNOSE?** (pick **one** of two headings)

The assessment aimed to rule out or confirm a diagnosis of autism. Our conclusion is that **XXX meets / does not meet** the criteria for this condition.

Insert brief formulation of why the diagnostic criteria was met or not met. \*Must\* include reference to:

* screening measures
* school report
* ADOS
* observations from clinical interview/developmental history
* developmental history

\*must\* include a rationale of why not diagnosed if ADOS was over threshold and/or school report was suggestive

If diagnosed, \*must\* include **four** examples of features observed that are in line with the diagnostic criteria (see example bullet point list below)

If NOT diagnosed, \*must\* include examples from the diagnostic criteria that are not in line with a diagnosis and can be seen as falling outside of autistic functioning, as well as acknowledging those that may be in line (see example bullet point list below)

{{Why\_We\_Diagnosed}}

**Example: not diagnosed**

Having reviewed all the information collected we concluded that there was not enough evidence for a diagnosis of autism, as the information provided by different sources was not consistent. For example, the school report and screening measures completed by school do not seem to point to features suggestive of autism. There is also no indication that XXX’s functioning and academic achievement at school is being impacted by the concerns raised in the referral. We do acknowledge that at home XXX appears to show features consistent with a diagnosis and it may be useful to monitor their functioning as they progress through education in case their presentation at school changes significantly. Furthermore, our independent assessment with them did evidence mild features that are sometimes observed in children with autism, but these were not sufficient to reach the threshold for a diagnosis.

Examples of features that are not in line with a diagnosis and can be seen as falling outside of autistic functioning include:

* Good ability to interact with others socially at school/home/other contexts
* Interest in engaging with others socially
* Good ability to engage with others in to-and-fro conversation
* Interest in sharing in own and others’ interests/experiences/emotions
* Good ability to respond socially to others
* Frequent use of a variety of non-verbal communication (e.g. gesture, eye contact, intonation, facial expressions)
* Evidence of a good ability to make and maintain friends
* Interest in establishing relationships with peers
* Good understanding of the reciprocal nature of social relationships
* Flexible use of language
* No evidence of repetitive movements, use of objects or speech
* Ability to cope with change and transitions
* Ability to consider alternative points of view and change own thinking accordingly
* Variety of hobbies and interests that are engaged with flexibly
* No evidence of sensory sensitivities or interests (to sound, texture, smell, touch, light and temperature)

**Example: not diagnosed**

Having reviewed all the information collected we concluded that there was not enough evidence for a diagnosis of autism. The history collected from parent/carer(s) and school indicated that XXX went through significant life events (e.g. loss, trauma, bullying, etc) that appeared to have a significant impact on them, with their presentation changing significantly following these. During our assessment we were not able to elicit any information regarding any features or difficulties being present prior to these events. We also understand that the family have not been able to access support regarding these that may have helped them process these events and therefore we believe that it is likely that their current functioning is more likely to reflect this history than being explained by a neurodevelopmental condition.

Examples of features that are not in line with a diagnosis and can be seen as falling outside of autistic functioning include: XXX

**Example: diagnosed**

Having reviewed all the information collected, we concluded that there was enough evidence to give XXX a diagnosis of autism. We acknowledge that the information was somewhat mixed with parents acknowledging that they had no concerns about XXX’s development until they transitioned to secondary school. However, when during the developmental history part of the assessment we were able to elicit some subtle features that appeared to have been present since a very early age (such as….). Also, it is not unusual for autism features to become more marked during transition periods and when the social demands and expectations increase, and we believe this might have been the case for XXX. The ADOS observation also indicated some clear features of autism and although these were not marked, they were consistent with a diagnosis. The information from school was also strongly suggestive and in line with other children with this condition. It was also clear that at present, XXX is struggling to cope with mainstream education and this seems to be linked to their social communication differences.

Examples of features observed that are in line with the diagnosis:

(pick **at least 4**)

* Limited social response during interactions
* Idiosyncratic ways of approaching others socially
* Reluctance to approach others socially
* Limited interest/ability to engage in to-and-fro conversations
* Reduced sharing of interests/experiences/emotions
* Reduced use of non-verbal communication (e.g. gesture, eye-contact, variation in tone of voice, facial expressions)
* Difficulties making and maintaining friendships
* Limited understanding of social relationships
* Reduced/absence of interest in peers
* Idiosyncratic use of language
* Repetitive motor movements, use of objects or speech
* Insistence on sameness/adherence to routines
* Ritualised patterns of verbal or non-verbal behaviours (e.g. lining up toys, performing routine tasks a set number of times, etc)
* Difficulties adjusting to transitions
* Inflexible patterns of thinking/behaviour
* Focussed/Highly specific interests
* Sensory sensitivities to sound/texture/smell/touch/light/temperature
* Sensory interests

**NOT DIAGNOSED: MOVING FORWARD***[delete section if not applicable]*

We have discussed the outcome of this assessment and offered the rationale for the decision that was made. We recommend that the family read through the materials enclosed/attached to this report.

Although a diagnosis of autism has not been given, this does not diminish the challenges faced by this young person and their family. The absence of a diagnosis does not mean an absence of autistic traits, and we recognise that reaching this point in the process may have taken time. It is completely understandable that coming to the end of the assessment pathway without a definitive explanation can feel frustrating or disappointing.

Some young people may display certain autistic traits, but these may not be significant enough, or present consistently across different settings, to meet the criteria for a diagnosis. In other cases, there may be different explanations for a young person’s presentation. Anxiety, low mood, trauma, and other forms of psychological distress can sometimes lead to behaviours that resemble autism, making it essential to consider a wide range of factors. Additionally, other neurodevelopmental conditions—such as ADHD—share overlapping characteristics with autism, and concerns around intellectual ability may also contribute to the way a young person presents.

We strongly encourage ongoing conversations with your GP and the school to explore the best ways to support this young person. While a diagnosis can be helpful, their needs go beyond a label, and the most important outcome is understanding how to meet those needs effectively.

If you have concerns about their mental health, your GP can advise on a referral to CAMHS. If there are concerns about general health and development, particularly for younger children, your GP may also refer to a paediatrician. Additionally, they may be aware of other local services that can offer support now that autism has been ruled out.

Every school will approach student support differently and sharing this report with them will provide valuable insights into how best to meet this young person’s needs, regardless of diagnosis. Open discussions with the school can help create the right support plan moving forward.

If you need any further guidance, please do not hesitate to contact us. We are here to support you in finding the next step on this journey.

**DIAGNOSIS: MOVING FORWARD** *[delete section if not applicable]*

We have discussed the outcome of this assessment and offered the rationale for the decision that was made. We have signposted to local services and other sources of further information and support. We recommend that the family read through the materials enclosed/attached to this report.

Every child and young person with autism will have a range of skills and abilities. They will also have individual needs that require us to adapt our teaching and environment so that they can thrive. We have moved away from labels such as “mild”, “moderate” or “severe”. No child or young person is any of these things. We all have fluctuating needs depending on our environment. A child who appears highly dysregulated in a supermarket may seem "severely autistic" in that moment yet thrive in a different setting when engaging in a special interest. Instead of labels, we focus on individual needs and strengths, adapting environments and support to help each child succeed.

Autism can potentially impact on a young person’s capacity to access and thrive in education. Specific recommendations for school or education are beyond the scope of this clinical diagnostic assessment and each school will have a unique policy on offering support to those young people who have additional needs. The outcome of this assessment should be discussed with school to establish what support is needed and the following suggestions should be considered.

To help a child reach their full potential and develop in a way that works best for them, it may be helpful to further understand their brain and the way it works. We recommend that all parent/carers attend a post-diagnosis workshop. To find a programme in your area, search your council’s “local offer”. If you're not ready immediately after the assessment, you can always refer later.

**RECOMMENDATIONS & FURTHER CONSIDERATIONS**

{{Recommendations\_and\_Further\_considerations}}

[Admin: **remove** **purple prompts and headings**, flag any actions]

[Clinician: only keep recommendations that are applicable. Complete any red prompts]

The following are tailored recommendations based on concerns discussed.

***ADHD Screening***

1. ***If only referred for autism assessment initially:*** Parent/guardian mentioned that XXX shows [impulsive behaviour at home]. The school report also noted [difficulties with regards to poor concentration, hyperactivity and fidgeting]. Observations from today’s assessment (e.g. XXX was unable to stay in the seat and frequently took movement breaks) also suggest that XXX may benefit from screening for attention deficit hyperactivity disorder (ADHD). Should parent/carer wish to consider further assessment, they are advised to discuss a new referral with their GP.
2. ***If referred for DUAL assessment initially but declined for ADHD:*** While XXX was originally declined for a dual assessment based on initial screeners measures, observations from today’s assessment suggest that an attention deficit hyperactivity disorder (ADHD) assessment may be appropriate. For example, parent/guardian mentioned that XXX shows [impulsive behaviour at home]. The school report also noted [difficulties with regards to poor concentration, hyperactivity and fidgeting]. In the clinic, XXX [was unable to stay in the seat and frequently took movement breaks]. Should parent/carer wish to continue with an ADHD assessment, they can email [righttochoose@psicon.co.uk](mailto:righttochoose@psicon.co.uk) (including their child’s full name and DOB) to request that the autism referral be re-opened.

***Speech & Language / Occupational Therapy / Ed Psych***

1. Concerns were raised about (insert concern). It is recommended that this is discussed with the school or GP, who can consider whether any onwards referrals to other services may be necessary.

***Physical Health***

1. In view of (insert concern e.g. bladder problems), it is recommended that parent/carer discuss this further with their GP.

***Sleep***

1. Parent/carer reported difficulty with sleep. Getting a good night’s sleep is essential for both the child, and carers. We recommend that family explore the following online resources related to sleep hygiene. If difficulties persist, contact the GP.

* [Cerebra Sleep Advice Service](https://cerebra.org.uk/get-advice-support/sleep-advice-service)
* [Scope – Sleep Right Service](https://www.scope.org.uk/family-services/sleep-right)
* [National Autistic Society – Sleep Guidance](https://www.autism.org.uk/advice-and-guidance/topics/physical-health/sleep)
* [YouTube Video on Sleep Strategies](https://www.youtube.com/watch?v=fEyrB3lKjSk)

***Mental Health Support (High severity)***

1. It was reported that (insert concern). Given the level of need, a referral has been made to the local mental health team. In the meantime, if there are any concerns regarding risk or safety, it is important to contact the GP, NHS 111 or 999, depending on the level of urgency.

Clinician action: email [NDLS.AP@psicon.co.uk](mailto:NDLS.AP@psicon.co.uk) if you require support with processing a referral on your behalf

Please note, if you would like to amend any of the above further considerations, please contact the clinical lead BEFORE adding to report or advising family/client to check if this is available in the local area or in line with the local agreements.

**SUMMARY AND SIGN OFF**

It was a pleasure to meet with XXX and their family today. We sincerely hope that this assessment will help further the understanding of their individual needs and provide some guidance for the future.

Yours sincerely,

**Clinician 1 Clinician 2 Clinician 3**Job Title Job Title Job Title

ENC:

1. Appendix – Autism screening questionnaires (either SRS or ASRS, delete as applicable)
2. Appendix – DSM-5 criteria for autism diagnosis
3. PDF – Post-assessment support

**Appendix – Autism Screening Measures (ASRS)**

The **Autism Spectrum Rating Scales (ASRS, Short Form)** is a screening tool used to explore a young person’s communication, social interaction preferences, and behavioural patterns across different environments. Completed by parents and teachers, it helps identify whether a full autism assessment is indicated and provides additional information to support the assessment process. While not diagnostic, the ASRS offers valuable insights into the young person’s unique strengths and needs in both home and school settings.

A T-score of 60-69 indicates elevated behaviours in that area compared to peers. A T-score of 70 and above suggests behaviours that are more significantly different and often align with the unique ways in which autistic individuals experience and interact with the world. Scores above 70 are commonly observed in areas like social communication, interaction preferences, and patterns of behaviour for individuals with autism, providing valuable insights to guide further assessment and support.

XXX’s scores are presented below.

|  | **T-score** | **Percentile** | **Range** |
| --- | --- | --- | --- |
| **Parent/Carer** |  |  |  |
| **School** |  |  |  |

Whilst these questionnaires are important to help a clinician decide on the presence or absence of a diagnosis, the final conclusion is based on all information collected during the assessment process. The outcome may be different from what the scores suggest. For example, it is not uncommon for scores between home and school to be different. Therefore the clinical expertise goes beyond the results to tease out features that may or may not be reflected on the scores of these quantitative measures.

**Appendix – Autism Screening Measures (SRS)**

The **Social Responsiveness Scale (SRS-2)** is a screening tool used to explore a young person’s communication, social interaction preferences, and behavioural patterns across different environments. Completed by parents and teachers, it helps identify whether a full autism assessment is indicated and provides additional information to support the assessment process. While not diagnostic, the SRS offers valuable insights into the young person’s unique strengths and needs in both home and school settings.

A T-score of 60-65 indicates mild to moderate difficulties relative to same-age peers. A T-score of 66-75 indicates moderate to severe difficulties, often aligning with behaviours seen in individuals with autism.

Higher scores reflect greater levels of social difficulty. These scores can highlight particular challenges in how a young person interprets and responds to social situations, enabling more tailored support strategies to be developed across both home and school environments.

XXX’s scores are presented below.

|  | **T-score** | **Percentile** | **Range** |
| --- | --- | --- | --- |
| **Parent/Carer** |  |  |  |
| **School** |  |  |  |

Whilst these questionnaires are important to help a clinician decide on the presence or absence of a diagnosis, the final conclusion is based on all information collected during the assessment process. The outcome may be different from what the scores suggest. For example, it is not uncommon for scores between home and school to be different. Therefore, the clinical expertise goes beyond the results to tease out features that may or may not be reflected on the scores of these quantitative measures.

**Appendix - DSM-5 Criteria for Autism Diagnosis**

A diagnosis of ‘autism spectrum disorder’ requires that the following criteria are met:

**A) Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following:** *(Must meet all three criteria)*

* Deficits in social-emotional reciprocity
* Deficits in nonverbal communicative behaviours used for social interaction
* Deficits in developing, maintaining, and understanding relationships

**B) Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following:**

* Stereotyped or repetitive motor movements, use of objects, or speech
* Insistence on sameness, inflexible adherence to routines, or ritualised patterns of behaviour
* Highly restricted, fixated interests that are abnormal in intensity or focus
* Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment

**C) Symptoms must be present in the early developmental period**

**D) Symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning**

**E) These disturbances are not better explained by intellectual disability or global developmental delay**