# Tasmanian Autism Diagnostic Service (TADS) Referral Form

## Child and Family Section

<table>
<thead>
<tr>
<th>Name of Individual:</th>
<th>☐ Female ☐ Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of Parents/Carers</td>
<td>Date Of Birth:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Home Ph:</td>
<td>Mobile:</td>
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</tbody>
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## Details of Referrer

- ☐ Paediatrician
- ☐ Psychiatrist
- ☐ Psychologist

Please see checklist below for Psychologist and Psychiatrist referral

<table>
<thead>
<tr>
<th>Name:</th>
<th>Email:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
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</tbody>
</table>

Has an Autism Spectrum Disorder assessment been attempted/completed in the past? ☐ Yes ☐ No

If yes, by whom?

Reason for referral: Please briefly describe why you are seeking an autism spectrum diagnostic assessment:

Hearing testing has been: ☐ Initiated ☐ Completed ☐ Not a concern Result___________________________

Vision testing has been: ☐ Initiated ☐ Completed ☐ Not a concern Result___________________________

Has a cognitive, developmental or adaptive assessment been undertaken? ☐ Yes ☐ No

Has a speech pathology assessment been undertaken? ☐ Yes ☐ No

Has medical and/genetic screening been undertaken? ☐ Yes ☐ No

Has the guardian provided **verbal consent** for exchange of information and referral to the service? ☐ Yes ☐ No

Referrer signature: ___________________________ Date: _______________________

☐ I have provided the family with the parent/guardian section or ☐ TADS to provide

## Checklist

- ☐ Part of our assessment process includes the requirement for a Paediatric review prior to undertaking the autism diagnostic assessment. Please inform the family that a referral will be required from the GP to a Paediatrician if the child **has not** at some point been seen by a Paediatrician in relation to social or behavioural concerns.
- ☐ Letter from Paediatrician; we would greatly appreciate the results of any relevant medical checks and/or a copy of Paediatricians letter sent to the child’s referring GP. Please attach a copy if available.
- ☐ Cognitive, adaptive, or developmental assessment. Please attach a copy if available.
- ☐ Communication/speech and language assessment. Please attach a copy if available.

Please mail: GPO Box 125, HOBART 7001 or fax referral: 6230 7547

Tasmanian Autism Diagnostic Service – Referral Form 2015

Mail: GPO Box 125 HOBART TAS 7001 Phone: 03) 61 661100 Fax: 03) 6230 7547

autismassessment@dhhs.tas.gov.au