 **Wiltshire Autism Hub Referral Form**

*Referral criteria: client must live in Wiltshire local authority area, be 14+ years old and have an existing autism diagnosis. Please ensure that the person has agreed to this referral.*

We can provide short term direct assistance to help with particular issues or to help achieve a specific goal, such as understanding autism, helping to develop coping skills for life or applying for benefits. We offer 1-2-1 support, peer group support and travel training support. The hub was also created to provide signposting to further advice and guidance to support individuals, families, parents, carers and professionals. <https://www.wsun.co.uk/wiltshire-autism-hub/>

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| **Date of Referral** |  |
| **Name of Referral Contact** |  |
| **Referring Organisation** |  |
| **Telephone Number** |  |
| **Email**  |  |

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| --- | --- | --- | --- |
| **Name of client** |  | **Date of Birth** |  |
| **Home Address** **Postcode** |  | **Tel No****Mobile No** |  |
| **Email** |  |
| **Preferred method of contact** | Email / Text / Phone |

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| **Date of Autism diagnosis** | *Please include proof of diagnosis (eg photo of letter) with referral form* |

Please turn over

Please supply as much information as possible.

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| **Reason for referral****Overview****Issues to be addressed and Goals** |  |
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| **Any mental health, disability or long term conditions** |  |
| **Any areas of concern or safety issues** |  |