**WESTERN BAY INTEGRATED AUTISM SERVICE CONSENT FORM**

**Individual Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | DOB |  | |
| Address |  | | | |
| Tel No |  | Mobile | |  |
| Email |  | | | |
| GP Details |  | | | |
| GP Name |  | | | |
| Surgery Address |  | | | |
| Tel No |  | | | |

* Would you be willing/able to attend a short notice/same day notice appointment Yes/No (*please indicate*)
* Have you previously been seen for an assessment of Asperger Syndrome or Autism? Yes/No (*please indicate*)
* If yes, please provide details: -----------------------------------------------------------------------
* Have you already received a diagnosis of Asperger Syndrome or Autism? Yes/No (*please indicate*)

If yes, please provide details: ----------------------------------------------------------------------

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| --- |
| CONSENT |

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| --- |
| **I DO / DO NOT** (*please indicate*) consent to the referral that has been made on my behalf for an assessment of Autism Spectrum Disorder.  **I DO / DO NOT** (*please indicate*) consent to a questionnaire being completed on my behalf by a family member/partner/close friend.  **I DO / DO NOT** (*please indicate*) consent to a relative attending an appointment to provide additional developmental information.  ***If you intend to bring a relative to the appointment, please provide their details below.*** |

|  |  |  |  |
| --- | --- | --- | --- |
| RELATIVE DETAILS | | | |
| Name |  | Relation |  |
| Tel No |  | Mobile |  |
| Email |  | | |
| Address |  | | |

|  |
| --- |
| Signature of referred individual: ---------------------------------------------- Date ---------------------- |