Dear Parents/ Carers,

Your child/young person is being considered for an assessment as there are concerns about their development. We need questionnaires from both home and school to gather as much information as possible to help the team decide the most appropriate type of assessment. The information provided is an important part of the full assessment for your child and will hopefully assist in reaching any appropriate diagnosis, as well as informing the evaluation of their needs The questionnaires look at a range of areas and it is important that, where possible, all questions are answered with examples.

We would be grateful if you could complete the parent questionnaire and return it to the referrer e.g., your GP, teacher etc. If you have any questions about completing the form, please go back to the referrer who gave you the questionnaire.

Once all questionnaires have been received, we will be able to review the referral and determine whether an assessment would be appropriate for your child. By completing this questionnaire, we are assuming consent to collect and share information with your child’s educational setting in order to obtain high quality information for this assessment process.

**Instructions:**

* Please provide as much detail as possible and if you can, give examples?
* If there are sensitive issues you would like to disclose but not be discussed in front of the child at the assessment, please document here. However, if the clinician feels this is important to raise, they will discuss with you beforehand, please make note in the further comments.
* There is space on the final page for any additional information.

Thank you for taking the time to complete this questionnaire. This questionnaire forms part of the referral to the Single Point of Access (SPOA) for Neurodevelopmental assessments

**Insufficient information may lead to the request for an assessment not being accepted.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Child/ Young person’s details** | | | | | | | |
| Child /young person’s name: |  | | | | Child/young person’s  D.O.B: | |  |
| Female ☐ Male | | | | |
| Name of School/Playgroup/ Nursery: |  | | | | Year Group: | |  |
| Address of School/ Playgroup/Nursery: |  | | | | | | |
| Home Educated | Yes (please provide more details below) No ☐ | | | | | | |
| Tutor or Education provider |  | | | | | | |
|  | | | | | | | |
| **Family background** | | | | | | | |
| At home, my child lives with…  As part of exploring your child’s difficulties it is helpful to understand any life experiences that may have affected them during their childhood.  Has your child experienced adverse life experiences including exposure to domestic violence, parental mental health difficulties, parental alcohol or drug misuse, parental separation or divorce, parent in prison, physical, sexual, emotional abuse or neglect?  If so, what was the frequency and duration of their experiences?  *Please give details below:* | | | | | | | |
| **Outline any difficulties your child has in relationships with family members / people who live in the same house as them:**  *Please give details below:* | | | | | | | |
| **Are there other people who also look after your child who do not live at your child’s address, who may also be able to provide information on your child’s difficulties?** *(e.g., Child Minder, other relatives etc.)*  *Please give details below:* | | | | | | | |
|  | | | | | | | |
| **Professionals involved with the child (please state details if known)** | | | | | | | |
|  | | | **Past Involvement**  *Please describe* | | | **Current Involvement**  *Please describe* | |
| GP | | |  | | |  | |
| Community Paediatrician | | |  | | |  | |
| Health Visitor/School Nurse | | |  | | |  | |
| Speech and Language Therapist | | |  | | |  | |
| Clinical Psychologist | | |  | | |  | |
| Educational Psychologist | | |  | | |  | |
| Early Years Inclusion Team  *(e.g., Portage, EYCN, SENCO)* | | |  | | |  | |
| Language(s) spoken at home.  (*Please indicate child's main language)* | | |  | | |  | |
| Occupational Therapy | | |  | | |  | |
| CAMHS | | |  | | |  | |
| Physiotherapy | | |  | | |  | |
| Social Worker | | |  | | |  | |
| **Others – please list below:** | | |  | | |  | |
|  | | | | | | | |
|  | | | | | | | |
| **Assessment - Please complete with as much detail as possible** | | | | | | | |
| **What are your main concerns about your child?**  *Please describe.*  **Is there a condition that you feel they may have?**  *Please describe.* | | | | | | | |
| **Development - If any question is not applicable, please move on to the next question** | | | | | | | |
| **Does your child have any development delays or learning difficulties:**   |  |  | | --- | --- | | Yes | No |   *If yes, please specify:* | | | | | | | |
| **Outline any difficulties your child has in turn taking and responding to other people** *(e.g., in conversation and play)*  *Please describe.* | | | | | | | |
| **Outline any difficulties your child has in using and understanding non-verbal communication.**  *(e.g., facial expression, eye contact, gesture, tone of voice)*  *Please describe.* | | | | | | | |
| **Outline any difficulties your child has with friendships and seeing from another person’s point of view:**  *Please describe.* | | | | | | | |
| **Does your child have any interests which are extreme in their focus, unusual, or take up most of their time and attention (in excess of those of similar aged children):**  *Please describe:* | | | | | | | |
| **Does your child have any particular routines or rituals or have extreme difficulty with changes to plans or to the environment?**  *Please describe:* | | | | | | | |
| **Does your child show any repetitive or unusual use of language / movements or use of objects:**  *Please describe:* | | | | | | | |
| **Does your child show any sensory differences** *e.g., seek unusual sensory input or show distress / avoid sensory input? (Sensory input might include noise, touch, smell, taste, visual, movement).*  *Please describe:* | | | | | | | |
| **Behaviour concerns:** *(e.g., poor sleep, dietary concerns, aggression / self-harm, mental health difficulties, danger awareness).*  *Please describe.* | | | | | | | |
| **Activities of Daily Living -** *If not applicable, please move on to the next section* | | | | | | | |
| Please provide examples of the checked boxes below, and how their difficulties affect their ability to carry out daily activities: | | | | | | | |
|  | |  | | Please give details below: | | | |
| Independence with personal care (e.g., toileting, washing, dressing, eating) | |  | |  | | | |
| Organisational skills at home and school | |  | |  | | | |
| Fine or gross motor skills e.g., using a knife and fork, riding a bike, catching a ball. | |  | |  | | | |
| **Any Additional Needs***: (include other existing conditions)*  *Please give details below:* | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| **What information and support have you / your child accessed:***e.g., Family Support/Time Out for ASD/Other:*  *Please give details below:* | | | | | | | |
|  | | | | | | | |
| **What strategies have helped/not helped?**  *Please give details below:* | | | | | | | |
|  | | | | | | | |
| **What are the three areas of strength for your child?**  *Please give details below:* | | | | | | | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| **What are the three areas that cause you the most concern?**  *Please give details below:* | | | | | | | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| **What would most like help with for your child?** | | | | | | | |
| *Please give details below:* | | | | | | | |
| **Is there any family history of the following?** | | | | | | | |
| **Autism Spectrum Disorder or ADHD.**   |  |  | | --- | --- | | Yes | No |   *If yes, please give details below:* | | | | | | | |
| **Learning difficulties including specific difficulties such as dyslexia?**   |  |  | | --- | --- | | Yes | No |   *If yes, please give details below:* | | | | | | | |
| **Mental health difficulties e.g., anxiety, depression, psychoses, schizophrenia**.   |  |  | | --- | --- | | Yes | No |   *If yes, please give details below:* | | | | | | | |
| **Genetic conditions.**   |  |  | | --- | --- | | Yes | No |   *If yes, please give details below:* | | | | | | | |
| **Medical History** | | | | | | | |
| **Were there any problems during the pregnancy?**  **Was mum taking any medications during this time?**  **Any smoking, alcohol or illicit drug use by Mum?**  *Please give details below:* | | | | | | | |
| **Were there any problems or concerns during labour or following birth?**   |  |  | | --- | --- | | Yes | No |   *If yes, please give details below:* | | | | | | | |
| |  |  | | --- | --- | | Yes | No |   **Has your child ever been admitted to hospital or been under review by a consultant or regular review with the GP for a specific condition?**  *If yes, please give details below:* | | | | | | | |
| **Does your child take any liquid medicines, tablets, inhalers etc.?**   |  |  | | --- | --- | | Yes | No |   *If yes, please give details below:* | | | | | | | |
|  | | | | | | | |
| **How would you rate your child/young person in terms of the level of the following:** | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never** | **Occasionally** | **Often** | **Very Often** | **Please give details/examples** |
| 1. Fails to give close attention to detail or makes careless mistakes in schoolwork or tasks |  |  |  |  |  |
| 2. Has difficulty sustaining attention in tasks or play activities |  |  |  |  |  |
| 3. Does not seem to listen when spoken to directly |  |  |  |  |  |
| 4. Does not follow through on instructions and fails to finish schoolwork, chores, or duties |  |  |  |  |  |
| 5. Has difficulty organising tasks and activities |  |  |  |  |  |
| 6. Avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort |  |  |  |  |  |
| 7. Loses things necessary for activities (e.g., toys, school assignments, pencils, or books) |  |  |  |  |  |
| 8. Is often distracted by extraneous stimuli |  |  |  |  |  |
| 9. Is often forgetful in daily activities |  |  |  |  |  |
|  |  |  |  |  |  |
| 10. Fidgets with hands or feet or squirms in seat |  |  |  |  |  |
| 11. Leaves their seat in classroom or in other situations in which remaining seated is expected. |  |  |  |  |  |
| 12. Runs about or climbs excessively in situations in which it is inappropriate |  |  |  |  |  |
| 13. Has difficulty playing or engaging in leisure activities quietly |  |  |  |  |  |
| 14. Is often “on the go” or acts as if “driven by a motor” |  |  |  |  |  |
| 15. Talks excessively |  |  |  |  |  |
| 16. Blurts out answers before questions have been completed |  |  |  |  |  |
| 17. Has difficulty awaiting their turn |  |  |  |  |  |
| 18. Interrupts or intrudes on others (e.g., butts into conversations/ games) |  |  |  |  |  |
|  |  |  |  |  |  |
| 19. Loses their temper |  |  |  |  |  |
| 20. Often argues with adult |  |  |  |  |  |
| 21. Actively defies or refuses adult requests or rules |  |  |  |  |  |
| 22. Deliberately does things that annoy other people |  |  |  |  |  |
| 23. Blames others for his or her mistakes or misbehaviour |  |  |  |  |  |
| 24. Touchy or easily annoyed by others |  |  |  |  |  |
| 25. Can be angry and resentful |  |  |  |  |  |
| 26. Can be spiteful or vindictive |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | | |
|  | **Yes** | **No** |
| Is your child working at age related expectations? |  |  |
| Is your child on the SEN register? |  |  |
| Have they experienced exclusions because of their current profile? |  |  |
| Are they struggling to reach potential because of current profile? |  |  |
|  |  | |
| **Please give details of above and anything else you feel relevant for referral:** | | |

|  |  |  |
| --- | --- | --- |
| **Person completing this form:** | | |
| **Name:** | **Address:** | |
| **Relationship:** | **Email:** | **Date Completed:** |
| **Telephone:** |

**Once completed, please return this questionnaire to the original referrer as soon as possible.**

**Thank you once again for completing this questionnaire. All the information that you have provided is very important and will allow us to better assess the child/young person.**