Neurodevelopmental Pathway Parent/Carer Questionnaire

Dear Parents,

Your child has been referred due to concerns which have suggested that an assessment for neurodevelopmental difficulties such as ASD or ADHD would be indicated.

To initiate this process we use screening questionnaires for information from both the home and school setting. This is done in order to capture the full range of possible behaviours and to help identify the next steps including directing the referral to the right service for assessing your child.

It is important that where possible all questions are answered. However, we use standard questionnaires for all ages and there might be a number of questions that may not seem relevant to your child. If so you can strike a line through any questions that seem inappropriate.

We would be grateful if you complete the parent questionnaire/s and send to the referrer eg. your GP, teacher etc.

Yours Sincerely,

On behalf of SPOA

Parent/Carer Questionnaire

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. If you have any questions about completing the form please go back to the referrer who gave you the questionnaire. 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.
Instructions: Please complete this questionnaire and return as soon as possible to the address at the bottom of the questionnaire. Please complete in black ink. Thank you.

Child's Name:	**Date of birth:**
Form completed by (name):	**Date:**
Address your child lives at:	
Telephone number:	
Name of School/playgroup/nursery:	
Which of the following professionals are involved with your child?	
GP	
Community Paediatrician	
Health Visitor/School Nurse	
Speech and Language Therapist	
Clinical Psychologist	
Educational Psychologist	
Portage/Early Years Teacher	
Other Professionals	
Language(s) spoken at home (please indicate child's main language)	
Background information	
Who lives with your child?	
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.)	

Is there any family history of the following?
Autism Spectrum Disorder or ADHD
Learning difficulties including specific difficulties such as dyslexia?
Mental health difficulties eg anxiety, depression, psychoses, schizophrenia
Genetic conditions

Medical History
Were there any problems during the pregnancy or birth of your child?
Has your child ever been admitted to hospital or been under review by a Consultant? No/Yes **If yes please provide further details below:**
Does your child take any liquid medicines, tablets, inhalers etc.? **If Yes please give details below:**

Current Concerns
What are you particularly concerned about at this point in time?
Are there any aspects of behaviour that are difficult to manage?
Are there any particular areas of strength?

Do you have concerns about any of the following areas:		
Development/Learning please mention if your child has learning difficulties/has the child lost any skills or abilities	**No concerns** ☐	**Yes** (please give details)
Play	**No concerns** ☐	**Yes** (please give details)
Communication	**No concerns** ☐	**Yes** (please give details)

Social Skills	**No concerns** ☐	**Yes** (please give details)
Concentration	**No concerns** ☐	**Yes** (please give details)
Hyperactivity levels	**No concerns** ☐	**Yes** (please give details)
Anxiety	**No concerns** ☐	**Yes** (please give details)
Sleeping	**No concerns** ☐	**Yes** (please give details)
Eating	**No concerns** ☐	**Yes** (please give details)
Sensory needs	**No concerns** ☐	**Yes** (please give details)
Is there any risk to your child from themselves or others?	**No concerns** ☐	**Yes** (please give details)
If there is any further information you would like to provide, please do so in the space provided below:		

This form is part of the SPoA referral:

Please return the completed questionnaire to the referring GP practice
or
If you are the referring school: please attach to the SPOA referral form, with the completed parent/guardian questionnaire and return to the SPOA address on the referral form. Thank you