**Referral Form**

**Autism Empowerment, Support, and Education Service**

**1. Referral Source**

☐ Self-referral
☐ GP / NHS Service
☐ Derbyshire County Council Adult Care Social Worker
☐ VCSE Organisation
☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Referring Person Details (if self-referring skip to question 3)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Role/Relationship to Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Organisation (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Applicant Details**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Eligibility Criteria (tick all that apply)**

☐ Received an autism diagnosis
☐ Awaiting an autism diagnosis
☐ Self-identify as autistic
☐ Family member/carer of an autistic person

**5. Support Needs (tick all relevant areas of concern)**

☐ Understanding autism and self-identity
☐ Sensory processing challenges
☐ Executive function and daily management skills
☐ Mental health and emotional wellbeing
☐ Social relationships and community engagement
☐ Employment and education support
☐ Understanding rights and reasonable adjustments
☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Preferred Support Format**

☐ 1-2-1 Coaching
☐ Group Training Course
☐ Combination of Both
☐ Not Sure – Needs Initial Assessment

**7. Additional Information**

Please provide any other relevant details, including previous support received, risk concerns, or specific access needs:

**8. Consent & Declaration**

☐ I confirm that the individual named above has consented to this referral.
☐ I consent to being contacted regarding this referral.
☐ I consent to my data being stored and processed in accordance with GDPR policies.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Submit this form to **referrals@derbyshireautismese.co.uk**. We will acknowledge receipt within 48 working hours.