**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.