Specialist Youth Autism Diagnostic Clinic

The Autism Association of Western Australia is pleased to be able to offer free, multidisciplinary assessments for Autism Spectrum Disorder (ASD) for adolescents and adults aged 13 to 30 years. Our assessment team consists of a Consultant Psychiatrist, Psychologist and Speech Pathologist.

We have a limited number of assessment places available in our clinic. To make a referral to this service, please read and complete the attached guide. It is essential that you address the criteria outlined in this document. This will assist us to determine the suitability of referrals and prioritise them accordingly.

This referral form must be completed by a GP, Consultant Psychiatrist or Consultant Paediatrician, and must be accompanied by a referral letter. Where possible, the referral should also include relevant previous clinical reports and correspondence regarding any pervious diagnostic assessments for ASD. Incomplete referrals, or those that do not address the criteria contained in this form, may be declined.

Please note - we are a diagnostic service only. We do not offer psychiatric assessments beyond those required to address the question of an ASD diagnosis. We also cannot prescribe or adjust medications; or provide ongoing case management. In addition, we are not an emergency or acute mental health service. If you are intending to refer a young person with significant mental health concerns, please also refer them to relevant Community Mental Health Services.

Eligibility

In order to be eligible for an ASD assessment with our clinic, the following criteria must be met:

- Aged between 13-30 years (inclusive)
- Have a Medicare card
- A parent or family member who knew the young person well as a child is able to attend parts of the assessment to provide a developmental history
- There is sufficient evidence from the developmental history that suggests ASD
- Experiencing ongoing difficulties in a range of areas (e.g., schooling, daily life), that could be attributed to ASD

Referrals will NOT be accepted if the young person is currently experiencing:

- An acute episode of psychiatric illness
- A substance use disorder
- An acute starvational state related to an eating disorder

This is due to the likely confounding influence of these conditions on the assessment for an underlying ASD. Referrals will also be declined if the young person or their family has not given consent for the assessment, or not indicated their willingness to proceed.

Referrals characterised by significant complexity or other confounding factors may not be considered suitable for our clinic due to the intensive, one-day structure of our assessment process.

[1] Key Information based on recommendations from the Autism CRC National Guidelines - https://www.autismcrc.com.au/knowledge-centre/resource/national-guideline

Key Referral Information

The key information[1] outlined below will enable our diagnostic team to triage referrals. The below information may be included in your referral letter or you may prefer to complete this form and attach it as a supplement to your referral. Please address all criteria in your referral.

Section 1 – Details of Person Attending for Assessment

Surname: _____

First Name: _____

Preferred Name: _____

Gender: _____ Preferred Pronoun: _____

Date of Birth: _____ Medicare Number: _____

Address: _____

Email address: _____

Contact Number: _____ English as second language? ☐ Yes ☐ No

Preferred language: _____ Interpreter required: ☐ Yes ☐ No

Preferred contact method: ☐ Phone ☐ Email

Who is the best person to contact in relation to this referral? ☐ Self ☐ Parent ☐ Other: _____

Has the young person previously been assessed for ASD? ☐ Yes ☐ No

If yes – what was the outcome of this assessment?

_____

_____

Can the young person (or their parent or caregiver) provide documents relating to the previous assessment (e.g., who, when, where, assessments administered, diagnostic outcome) ☐ Yes ☐ No ☐ N/A

Section 2 – Details of Informant (Parent/Caregiver/Guardian)

If contact details differ from those above, please provide the best contact number and email address:

Contact Number: _____ Email Address: _____

Is there an informant who can provide a developmental history for this young person?
(**If no**, please do not proceed with the referral until there is an available developmental informant) ☐ Yes ☐ No

Given Name: _____ Surname: _____

Relationship to Client: ☐ Parent ☐ Carer ☐ Guardian ☐ Other (please specify): _____

Can the young person or their caregiver provide written information from childhood (e.g., school reports, previous assessments), to support this referral? ☐ Yes ☐ No

Section 3 – Details of Referrer

Name: _____

Profession: _____

Medicare Provider No. _____

Practice Address: _____

Contact Number: _____

Email: _____

Referral date: _____

Referrer Signature: _____

Section 4 – ASD Related Signs and/or Symptoms

Some of the key signs and/or symptoms of ASD in adolescents and adults are listed here. This is intended to provide guidance about commonly reported signs and/or symptoms of ASD for this age group and is not an exhaustive list. Under each heading, please comment on any signs and/or symptoms that you have observed or that have been reported to you about the young person.

1. Please provide examples of current and/or childhood difficulties the young person has with **Social Interaction**, e.g., conversational difficulties, reduced understanding of friendship or other relationships, reduced awareness of socially expected behaviour, difficulty making and maintaining friendships, social isolation and apparent preference for being alone, difficulty understanding social situations.

2. Please provide examples of current and/or childhood difficulties the young person has **nonverbal communication**, e.g., reduced, atypical, or poorly integrated use of gestures and facial expressions, reduced ability to read and interpret others' nonverbal cues (e.g., tone of voice, facial expressions), absent, reduced, or atypical use of eye contact, monotonous tone.

3. Please provide examples of current and/or childhood difficulties the young person has with **Restricted and Repetitive behaviors**, e.g., hand flapping, spinning and finger flicking, resistance to change, highly specific interests or hobbies, restricted range of interests, literal thinking, strong adherence to familiar routines, echolalia, repetitive speech.

4. Please provide examples of current and/or childhood difficulties the young person has with **Sensory Processing**, e.g., over- or under-sensitivity to touch, smell, taste, noise, or pain.

Section 5 – Psychosocial History

5.1 Please provide details of any existing diagnoses, including neurodevelopmental conditions (e.g. learning disabilities, intellectual disability, ADHD) or psychiatric conditions:

5.2 Please describe current or previous contact with mental health or disability services:

5.3 Please describe current or previous difficulties obtaining, attending or sustaining education or employment:

5.4 Please describe any barriers the young person may have in attending an appointment at a clinic:

5.4 Will the young person and/or their family find it difficult to complete paperwork (e.g., intake forms) in written English?

☐ Yes ☐ No

5.5 Please confirm that the individual is **NOT**:

☐ Currently experiencing an acute episode of psychiatric illness
☐ Currently using illicit substances
☐ Currently at risk of harm to self or others

Section 7 – Consent

The rationale for this referral has been discussed with the young person and/or their caregiver and they have:

☐ Given their consent to be contacted by the Specialist Youth Diagnostic Service at the Autism Association of Western Australia.
☐ Indicated that they understand that they are being referred for an ASD assessment, and that they are willing to proceed with this referral.

Section 8 – Clinical Correspondence

☐ Please indicate that relevant reports, clinical correspondence and results of previous assessments have been included with this referral

Referrals should be addressed to:

Dr Kelly McKenna-Kerr
Consultant Psychiatrist
Youth Autism Diagnostic Clinic
Autism Association of WA
215 Stubbs Terrace
Shenton Park, WA 6008

If you have any questions about the information provided in this booklet please do not hesitate to contact the clinic coordinator at **(08) 9489 8900** or email: youthadult.diagnosis@autism.org.au