To access P.A.S.S. Advice Service you must be aged 18 or over, have a diagnosis of autism/ ASD and be registered to a Plymouth GP.

Please complete this form to the best of your ability. If you need help filling out this form, please email [livewell.pass@nhs.net](mailto:livewell.pass@nhs.net) or call 01752 434034 or ask someone you trust to help you.

If you have a letter or a report that confirms your diagnosis of autism, please enclose a copy with your referral form.

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| --- | --- | --- | --- | --- |
| **Your Details** | | | | |
| **Full Name** | First:  Surname: | **Address**  **Postcode** | |  |
| **What I like to be called** |  | **Date of Birth** | |  |
| **NHS Number**  **(If known)** |  | | | |
| **Home Number** |  | **Mobile Number** | |  |
| **Email – Please read the email disclaimer at the bottom of the form.** |  | | | |
| **Do you require an interpreter?** | □ Yes  □ No | **If yes, which language do you require?** | |  |
| **Preferred Method of contact** | □ Home phone  □ Mobile Phone  □ Livewell Connect (video conferencing)  □ Text  □ Email | | | |
| **Do you want us to contact anyone on your behalf (e.g. parent, friend) when arranging an initial appointment?** | □ Yes. Please ask this person that it is ok you pass on their contact details.  □ No | | If yes, please provide details:  Name  Phone Number:  Email: | |

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| --- | --- | --- | --- |
| **GP Details** | | | |
| **Surgery Name** |  | **Surgery Address** |  |

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| **Referrer Details (to be completed if this referral is not made by the person e.g. GP, parent, social worker)** | | | | |
| **Name** |  | | **Address** |  |
| **Phone Number** |  | | **Relationship to person named above?** |  |
| **Email** |  | | | |
| **Has the person named consented to referral to P.A.S.S.?** | □ Yes  □ No | Consent to P.A.S.S. referral for the person named above was discussed on \_\_\_/\_\_\_\_/\_\_\_\_ | | |

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| --- | --- | --- | --- |
| **Why do you require P.A.S.S. support? Details –** | | | |
| **Do you have a diagnosis of Autism Spectrum Disorder, Asperger’s, or any other Autism diagnosis?** | □ Yes  □ No | **Do you have a report/letter/information that confirms your Autism diagnosis?**  **(If yes, please include a copy along with the referral form)** | □ Yes  □ No |
| **In your own words, please state the reasons why you would like P.A.S.S. support (maximum 3 reasons)** | | | |

Please return this form to **livewell.pass@nhs.net** OR call 01752 434034 OR by post to:

**Plymouth Autism Spectrum Service, Westbourne Unit, Scott Business Park, Beacon Park Road, Plymouth, PL2 2PQ**

Disclaimer: Emails from your private email account to an NHS email account are not necessarily safe (encrypted and secure). So if you send this referral from your email account it is done so at your own risk, this means Livewell South West cannot guarantee the security of the information whilst it is in your inbox or when in transmission (being sent), however once it is received by P.A.S.S. it will be subject to all our high standards of security. When P.A.S.S. send you email from their NHS account it will be secure until it reaches your inbox, you will then take responsibility again. If you do not want to email your referral form you can call us on   
01752 434034 and speak to our team or post it to Plymouth Autism Spectrum Service, Westbourne Unit, Scott Business Park, Beacon Park Road, Plymouth, PL2 2PQ. When you meet us for the first time we will talk to you about the use of email and ask you to fill in a consent form.