ASGMA
Autistic Society Greater Manchester Area

www.asgma.org.uk
1114 Chester Rd, Stretford
Manchester, M32 0HL
Tel: 0161 866 8483
E-mail: **admin@asgma.org.uk**

18+ Referral Form

Please complete all the sections of this form. This will enable us to process your referral as soon as possible.

Details of Individual:	
Name of Person:	Age:
Gender:	Date of Birth:
Email Address:	
Telephone Number:	
Address:	
Local Authority:	

Details of Parent/Carer:	
Name:	
Telephone Number:	Date of Birth:
Email Address:	
Address if different from above:	

Referring Agent / Details of professional involved in individual's life:
Agency Name:
Contact Name:
Job Title:
Email Address:
Telephone Number:

Diagnosis Information:	
Date of ASC Diagnosis:	Diagnosed By:
Details of diagnosis (e.g. high-functioning, Asperger's):	

Additional Medical Condition: **Please tick below or use the space to inform us of any additional diagnoses**	
ADD ☐ OCD ☐ ADHD ☐ PDDNOS ☐ Dyslexia ☐ Tourette's ☐ PDD ☐ Dyspraxia ☐	Other:

Personal Funding:	
Are you in receipt of any Direct Payments/Individual Budgets/Disability Living Allowance? If so, please specify which:	

Employment/Voluntary:		
Organisation:	Date From:	Date To:

Other Information:	
Please give details of any allergies:	
Please give details of any dislikes or phobias:	
Please give details of any regular medication taken and what it is for:	
Please give details of what the individual likes to do. What interests/hobbies does the individual have?	
Please add any information that you think ASGMA should be made aware of.	
Equal Opportunities Monitoring: **For ASGMA to ensure that we are reaching all sections of the community please provide the following information:**	
Ethnic Origin:	Religion:
Data Protection Act:	
The information you have provided on this form will be used exclusively for our project and will be stored in accordance with the principles of the Data Protection Act 1998. We need your signed consent to hold the information on our databases. Please be assured it will be held for the purpose it as provided, and we will be sensitive with your information at all times.	
I consent to my information being held on the ASGMA database and I agree to inform ASGMA of any changes such as address, telephone number, medication etc.	
Signed:	Date:

Please return from :

Email: admin@asgma.org.uk

OR

Post: ASGMA Referrals 1114 Chester Road, Stretford, Manchester M32 0HL

FOR OFFICE USE ONLY

	Name	Date
Date referral form rec'd		
Referral acknowledged by/date:		
Passed for referral to (name and date):		
Entered on database by/date :		
Date of referral meeting (with/date)		
Free "taster" session offered? (Y/N)		
Date free taster session received if applicable		
Membership pack sent		
Completed membership form rec'd		
Payment rec'd		
Comments (e.g. detail of referral meeting, not eligible, follow-up details)		