**Neurodevelopmental Assessment GP Right To Choose Referral Form**

The Owl Centre provides comprehensive online neurodevelopmental services (autism and ADHD) for children, young people and adults (aged 7+), including assessments, titration, shared care, and annual reviews. These services align with the NHS Standard Contract and have been accredited and quality assured by the NHS Norfolk and Waveney Integrated Care Board (ICB) and NHS Hampshire and Isle of Wight Integrated Care Board (ICB).

As an approved Right to Choose provider, The Owl Centre meets key criteria:

* Holding a standard NHS contract with at least one Integrated Care Board (ICB).
* Being led by a named healthcare professional.

Our contracts ensure that GPs can have confidence in our commitment to diagnostic assessments, shared care agreements and delivering annual reviews for patients who are stabilised on medication (where applicable).

**Please send the completed form, along with the patient’s screening form and summary care record, to** **owl.rtc@nhs.net****.**

**Optional information: Any reports undertaken by previous or current professionals**

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| **Patient Details** |
| **Patient Name:** |  | **NHS Number:** |  |
| **DOB:** |  | **Email Address:** |  |
| **Tel:** |  | **Address:** |  |
| **Age:** |  |
| **Gender:** |  |

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| **Primary Contact Details (required for CYP referrals)** |
| **Contact Name:** |  | **Relationship to patient:** |  |
| **Living with patient Y/N** |  | **Tel:** |  |
| **Email:** |  |

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| **Accessible Information Standards** |
| Communication needs and health inequalities: e.g. Suitable for online assessment, interpreter required (please state language), hearing or visual impairment, other communication difficulties, mental or physical disability, learning difficulties, homelessness, deprivation, digital exclusion, etc. |

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| **GP Referrer Details** |
| **Referring GP:** |  | **Date of Request:** |  |
| **GMC Number:** |  | **Referring Practice:** |  |
| **Contact Number:** |  | **Practice Code:** |  |
| **Email Adress:** |  | **Practice Address:** |  |

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| **Reason for Referral** |
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| Referral Type (Please put an ‘X’ next to the relevant assessment) |
| **Autism Assessment**  |  | **ADHD Assessment** |  | **ADHD Titration** |  |

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| **Current Medication and Allergies** |
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| **Relevant Medical, Psychiatric and Forensic History**  |
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| **Risk** |
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| **Referral to** |
| Please confirm the name of the organisation the patient is being referred to: The Owl Centre |

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| **Local Integrated Care Board (ICB)** |
| **Name of current ICB (required)** |  |
| **Name of Mental Health Lead at local ICB (if known)** |  |
| **Contact telephone number of the above contact (if known):** |  |
| **Finance department contact information for billing at local ICB (if known). This is generally held by your surgery’s finance department/colleague:** |  |