Tel: 01392 829989
Website: www.epicsolutions.org.uk
Email: admin@epicsolutions.org.uk

NHS Right to Choose – GP Referral Form

Children & Young People's Autism Assessment Service (8–18th birthday)

About this referral

EPIC is a CQC-registered NHS provider holding an NHS Standard Contract with Devon ICB. Under the NHS Choice Framework, patients have the legal right to choose their provider of consultant-led outpatient services at the point of referral.

Please complete this form in full and return securely to:
rtcreferrals@epicsolutions.org.uk

1. PATIENT DETAILS

Full name	
Preferred name	
Date of birth	
Age at referral	
NHS number	
Sex assigned at birth	
Gender identity (if different)	
Address (including postcode)	
Home telephone	
Parent/carer mobile	
Email address	
Ethnicity	
First language	

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Interpreter required? (Y/N + language)	
Accessible communication needs	

2. PARENTAL RESPONSIBILITY & CONSENT TO REFER

Name of parent/carer with PR	
Relationship to child	
Does this person hold parental responsibility? (Y/N)	
Second person with PR (if applicable)	
Contact details for second PR holder	

Consent confirmed by referrer:

☐ Parent / carer with PR (or Gillick-competent young person) consents to this referral

☐ Consent to share clinical information with EPIC for the purpose of assessment

☐ Consent for EPIC to share assessment outcomes with the referring GP, school, and other relevant agencies

☐ Consent for EPIC to contact the family directly to arrange assessment

3. REFERRING GP & PRACTICE

Referring GP name	
GMC number	
GP practice name	
Practice address	
Practice ODS code	
Practice telephone	
Date of referral	

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4. RIGHT TO CHOOSE – REFERRER CONFIRMATION

Please confirm each of the following:

☐ The patient / family has been informed of their right under the NHS Choice Framework to choose any clinically appropriate NHS provider

☐ The patient / family has chosen EPIC Solutions Ltd as their provider

☐ I confirm this referral is clinically appropriate and meets EPIC's published acceptance criteria

☐ I confirm the patient is registered with an NHS GP in England

☐ I will continue to provide shared care for any medication initiated by EPIC, in line with local shared care protocols (or, where I am unable to, will discuss with EPIC at the earliest opportunity)

☐ I understand assessment outcomes and recommendations will be shared back to the GP record

5. ASSESSMENT REQUESTED

This referral is for:

☐ Autism assessment

Additional information about the assessment request:

6. CURRENT & PREVIOUS WAITING LISTS

Currently on an NHS waiting list for the same assessment? (Y/N)	
If yes, name of provider	
Date added to that waiting list	

Note: Patients cannot be on two NHS waiting lists for the same assessment simultaneously. If proceeding with EPIC, the referrer / family should request removal from the alternative list.

7. PRESENTING CONCERNS

Reason for referral – presenting concerns and impact on daily functioning:

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Duration of concerns / approximate age of onset:
Settings in which concerns are observed (home, school, social, etc.):

8. RELEVANT CLINICAL HISTORY

Please either complete below boxes or upload most recent GP history
Developmental history (pregnancy, birth, early milestones):
Significant medical history:
Mental health history (current and previous):
Family history (including neurodevelopmental, mental health):

Current medications:
Allergies:
Existing diagnoses:

9. SAFEGUARDING & RISK

Safeguarding status – tick all that apply:

☐ No known safeguarding concerns
☐ Child in Need (CIN)
☐ Child Protection Plan (CP)
☐ Looked After Child (LAC) / Care Experienced
☐ EHCP in place
☐ Social Care involvement (current or recent)

Named social worker (if known)	
Social worker contact details (if known)	

Risk information – tick all that apply:

☐ Self-harm (current or historical)
☐ Suicidal ideation / attempts
☐ Aggression / violence towards others
☐ Absconding / running away
☐ Eating difficulties
☐ Substance misuse
☐ Other risk – please detail below

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Risk details, including any current safety/risk management plan:

11. OTHER PROFESSIONALS INVOLVED

Please list any other professionals currently or previously involved (CAMHS, paediatrics, SALT, OT, EP, etc.), with dates and outcomes where known:

13. REFERRER SIGN-OFF

Name of referring GP	
Signature / electronic authorisation	
Date	

How to return this form

- Via email to rtcreferrals@epicsolutions.org.uk

We will acknowledge receipt within 3 working days and confirm acceptance onto the waiting list within 10 working days.

Questions? Contact our referrals team on 01392 829989