**Mind the Gap Monthly Drop-in Group – Sign up Sheet**

| The Monthly Drop-in Group is a social group for Autistic Young People **12** to **18** years old which runs **every second Thursday** of the month at the Hackney Ark (Downs Park Rd, London E8 2FP). Find out more [here](https://drive.google.com/file/d/1eaz2M2xh8nvwaydy-5zyAvoi0HIVhniS/view?usp=sharing).The Group is delivered by the Targeted Health Outreach Team and the Neurodevelopmental Team at Specialist CAMHS and is open to young people who have a diagnosis of Autism or are currently on an Assessment waiting list.***Please note this group is not suitable for young people who require a 1 to 1 level of assisted support.*** |
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|  |
| INFORMATION about the Young Person: |
| Surname: |  | Forenames: |  |
| Date of Birth:(DD/MM/YYYY) |  | NHS No:*(If known)* |  |
| Ethnicity: |  | Nationality: |  |
| Sex at birth: |  | Gender Identity:Pronouns: |  |
| Address: |   | Postcode: |  |
| **GP DETAILS: *Please note: We can only accept referrals under Hackney or City of London GP’s*** |
| Name: |  |
| Address Tel: |  |
| **Name of person(s) with parental responsibility:**  |
|   |  |  |  |
|  |  |  |  |
| **Contact Details:** |
| Parent/Carer: Phone number |  | Parent/Carer: Email Address |  |
| Young Person: Phone number |  | Please indicate if happy to be sent text reminders to the mobile phone: |
| **School Details:** |
| Name: |  |
| Address: |  |
| **Previous Service Engagement:** |
| **When was the young person diagnosed and by which service? (If currently on waiting list please indicate)**Click here to enter text.**Please indicate if the young person has received support from any of the services below previously or currently:**First Steps ☐ Specialist CAMHS ☐ CAMHS Disability ☐ Speech & Language Service ☐ Occupational Therapy Service ☐ Targeted Health Outreach Team ☐ Any other service: Click here to enter text. |
| **Information about the Young Person:** |
| Please tell us a bit about the young person, what they like, what they don’t like, if they have any specific sensory needs or requirements, preferred methods of communication, any access needs due to disability or health and any other information that might be useful for the group facilitators to be aware of.Click here to enter text.  |
| **Consent:** |
| Has the parent/carer consented to this referral? |  |  |
| Has the young person consented/been made aware of this referral? |  |  |
|  |
| Name and signature: |  |
| Date: |  |

***Next Steps:***

**Please send this form via email to huh-tr.mindthegap@nhs.net**

On receipt of this form the person making the referral will receive a call from one of the group facilitators on the phone number provided to discuss the information and needs of the young person and ask any questions they might have. If the young person is happy to speak on the phone they can speak directly with one of the facilitators, or their parent/carer can do that for them.

Please note that if the young person is deemed to have needs that require a 1:1 level of assisted support they might not be accepted into this group as we have 2 professionals running the group and cannot provide that level of individual assistance.