



Before providing us with your personal data, please ensure you have read our privacy policy on healthhorizons.org.uk

Please tick this box to provide consent for us to collect, store and share your personal data

1. Information about the person needing assessment / support

Name	
Date of Birth	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
NHS number	
Address	
Home phone	
Mobile number	
Email	
GP Name	
GP Address	
GP Phone number	

2. Relevant medical history

Do you have any medical problems or identified syndrome / diagnosis? Please summarise below

Are you on medication?	
Do you have any allergies?	

3. Nature of your difficulties?

What are your main concerns?

What is the impact on you and on others?



Do you have any concerns in the following areas? If so, please describe			
Attention and concentration			
Speech sounds			
Ability to express yourself			
Your understanding			
Social interaction			
Sensory difficulties			
Mental health			
Ability to regulate your emotions			
Gross motor and fine motor skills			
Hearing			
Vision			
Learning			
Ability to work and keep a job			
4. What has been done to date?			
What has been done already to support you?			
Any agencies currently involved e.g. Mental health team, social care etc (please list as necessary)	Name	Agency	Contact
What other services or professionals are involved? (please list as necessary)	Name	Agency	Contact
5. Education			
Any concerns in school			



when growing up?		
6. Employment History		
What is your occupation (if applicable)?		
How many jobs have you previously had? Please list		
Any difficulties working and holding on to jobs?		
7. Risk assessment		
Has there been any historical incidents of deliberate self-harm or suicidal ideation? Please provide dates.		
Do you feel you are a risk to yourself, to others or to property?		
Have emergency services been involved, if so when?		
8. Neurodevelopmental Assessment Information		
When there is an option, would you prefer a remote assessment or a face to face assessment ?	Remote	Face to face
9. What outcome would you like from an assessment by Health Horizons Limited? Please provide as much information as possible.		
10. Consent		



You have agreed to referral to this service and have given written consent below to exchange information between relevant agencies including health, as appropriate

11. Referrer Details

Name (if different from above)

Is this a self-referral ?
(If not, please note consent from person needing assessment is needed)

Agency if not self-referral

Address (if different from above)

Email (if different from above)

Phone (if different from above)

Signed:

Date: