Catholic Care Social Services Hunter-Manning
DIOCESE OF MAITLAND-NEWCASTLE

Counselling, Family & Clinical Services
P 02 4979 1172 **F** 02 4961 6710
E counselling@catholiccare.org.au

AUTISM ASSESSMENT REFERRAL

CatholicCare Social Services Hunter-Manning provides a gold standard Diagnostic Assessment Service based on current evidence for Autism Spectrum Disorders in children, adolescents and adults. Our comprehensive assessments are conducted by our psychologists whom have training and interest in Autism Spectrum Disorders.

The CatholicCare diagnostic assessment process takes approximately 4 face to face sessions. Our assessment consists of:

- Initial assessment consultation
- Comprehensive parent/carer interview using the Autism Diagnostic Interview – Revised (ADI-R)
- Formal observation of the child/adolescent/adult using the Autism Diagnostic Observation Schedule – Second Edition (ADOS-2)
- Informal observation (example, pre-school, school) if necessary
- Feedback session discussing assessment observations, recommendations for intervention, treatment and follow-up
- Comprehensive written report within one month of the assessment date, outlining assessment process, observations, diagnosis, recommendations and follow-up.

You do not need a Medicare referral for an autism assessment. However, Medicare rebates are available to children under the age of 13 years whom have been referred by a paediatrician or a child psychiatrist before the date of assessment.

Payment is to be made on the date of assessment and can be made using cash, EFTPOS or credit card. You also have the option of making regular payments towards assessment costs prior to each appointment.

If you would like to proceed with an assessment, please fill out the referral form enclosed. You can return the form to us by email, post or fax prior to the first appointment. Include copies of any reports that have been completed, such as paediatrician, psychometric assessment, speech and language, occupational therapy, school reports.

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AUTISM ASSESSMENT

Full Name of Person to be assessed: _____

D.O.B: _____ Country of Birth: _____ ☐ Male ☐ Female

Is the client of Aboriginal descent? _____ Is the client of Torres Strait Islander descent? _____

Client's Parent/Carer Details (if applicable): Marital Status of Parents (if applicable): _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone: _____

Mobile Phone: _____ Mobile Phone: _____

Email Address: _____ Email Address: _____

Is the client under the guardianship of Family & Community Services: _____

Name of the preschool/school attending: _____ Year: _____

Address: _____

_____

Contact Person: _____ Phone: _____

Email Address: _____ Fax: _____

Is the child in a support class: _____

Referred By: ☐ Parent ☐ Self ☐ GP ☐ Paediatrician ☐ Psychiatrist ☐ Psychologist
(Please attach/send copy of referral, if applicable)

Name of Referrer: _____

Reason for Referral: _____

_____

_____

Please return this completed form by: **Email:** counselling@catholiccare.org.au | **Fax:** 02 4961 6710
Post: Attention: Manager – Autism Assessments, CatholicCare, 50 Crebert St Mayfield NSW 2304