



Community Adult Autism Service (CAAS) Diagnosis Referral Form

SECTION 3 – Autism Spectrum Condition Screening Tool

THIS CAN BE GIVEN TO CLIENTS TO COMPLETE – MUST BE RETURNED TO GP/REFERRER

WE DO NOT ACCEPT OTHER SCREENING TOOLS, e.g., AQ10 or other tests you may find online

Please tick either 'yes' or 'no' to indicate whether the following behaviours are interfering significantly in your daily life.

Please also provide examples for all questions – WE CANNOT ACCEPT THE FORM WITHOUT THIS QUALITATIVE INFORMATION.

Part A	Social Interaction and Communication difficulties.	Yes	No
1.	Do you find social situations confusing?	<input type="checkbox"/>	<input type="checkbox"/>
	Please provide further information or examples		
2.	Do you find it difficult to make small talk?	<input type="checkbox"/>	<input type="checkbox"/>
	Please provide further information or examples		
3.	Do you tend to turn any conversation back onto yourself or your own interests?	<input type="checkbox"/>	<input type="checkbox"/>
	Please provide further information or examples		
4.	Are you good at picking up details and facts?	<input type="checkbox"/>	<input type="checkbox"/>

	Please provide further information or examples		
5.	Do you find it difficult to work out what other people are thinking and feeling?	<input type="checkbox"/>	<input type="checkbox"/>
	Please provide further information or examples		
6.	Do people think that you are rude even when this is unintentional?	<input type="checkbox"/>	<input type="checkbox"/>
	Please provide further information or examples		
7.	Have you always had difficulty making friends?	<input type="checkbox"/>	<input type="checkbox"/>
	Please provide further information or examples		

Please provide further information or examples in relation to Part A:

Part B	Restricted, Repetitive patterns of behaviour, Interests or Activities.	Yes	No
8.	Do you have unusually strong, narrow interests?	<input type="checkbox"/>	<input type="checkbox"/>
Please provide further information or examples			
9.	Do you do certain things in a very inflexible, repetitive way?	<input type="checkbox"/>	<input type="checkbox"/>
Please provide further information or examples			
10.	Do you seem under or over responsive to everyday sensations (e.g. light, noise, touch, smells, tastes)?	<input type="checkbox"/>	<input type="checkbox"/>
Please provide further information or examples			
Please provide further information or examples in relation to Part B:			

Total Score (No. of Yes's ticked)

PLEASE RETURN THE COMPLETED FORM TO YOUR GP/REFERRER