HART MEDICAL PRACTICE

GP Partners: **DR K SOE** GMC 6044540 **DR A GUPTA** GMC 5180320 **DR V GNANAVELU** GMC 6069

Right to Choose referral request

If you would like to request a right to choose referral for an Autism and/or attention deficit hyperactivity disorder (ADHD) assessment, please complete and return to the Practice. The Practice may contact you if further information is required prior to completing your referral.

I would like to have the following assessments (please tick all that apply).

☐ **Autism Spectrum Disorder (ASD)**

☐ **Attention Deficit Hyperactivity Disorder (ADHD)**

Full Name			
Date of Birth	/ /	**Address**	
Mobile Number			
Email Address			
Name of choose provider			

Symptom Checklist

Please tick or highlight any symptoms you experience regularly:

Attention and Focus (ADHD)

☐ Difficulty sustaining attention in tasks or conversations
☐ Easily distracted by external stimuli or own thoughts
☐ Frequently forgetful in daily activities
☐ Trouble organising tasks or managing time
☐ Avoidance or dislike of tasks requiring sustained mental effort
☐ Frequently losing items necessary for tasks (e.g., keys, phone)
☐ Fidgeting or restlessness
☐ Interrupting others or difficulty waiting your turn

Social Communication and Interaction (Autism)

☐ Difficulty understanding social cues or body language
☐ Challenges in maintaining conversations or relationships
☐ Preference for routines and resistance to change
☐ Intense focus on specific interests or topics
☐ Sensory sensitivities (e.g., to noise, light, textures)
☐ Difficulty with eye contact or facial expressions
☐ Feeling overwhelmed in social situations
☐ Repetitive behaviors or movements (e.g., hand-flapping, rocking)

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Additional Notes

[Use this space to describe any other concerns, experiences, or relevant history.]