

Specialist Youth Autism Diagnostic Clinic

The Autism Association of Western Australia is pleased to be able to offer free, multidisciplinary assessments for Autism Spectrum Disorder (ASD) for adolescents and adults aged 13 to 30 years. Our assessment team consists of a Consultant Psychiatrist, Psychologist and Speech Pathologist.

Oftentimes, ASD is first identified at school. While we are only able to accept referrals from a GP, Consultant Psychiatrist or Consultant Paediatrician, school staff (such as class teachers, Year Leads and School Psychologists) play a crucial role in the referral and assessment process. Therefore, we have developed this information guide to assist schools to gather and document information relevant for a referral to the Specialist Youth Autism Diagnostic Clinic.

We would encourage you to read and complete this guide in collaboration with families. The information can then be taken to an appointment with a medical specialist, who can make the relevant referral to our clinic.

Eligibility

In order to be eligible for an ASD assessment with our clinic, the young person must meet the following criteria:

- Aged between 13-30 years (inclusive)
- Have a Medicare card
- A parent or family member who knew the young person well as a child is able to attend parts of the assessment to provide a developmental history
- There is sufficient evidence from the developmental history that suggests ASD
- Experiencing ongoing difficulties in a range of areas (e.g. schooling, daily life), that could be attributed to ASD

Referrals will NOT be accepted if the young person is currently experiencing:

- An acute episode of psychiatric illness
- A substance use disorder
- An acute starvation state related to an eating disorder

Referrals characterised by significant complexity or other confounding factors may not be considered suitable for our clinic due to the intensive, one-day structure of our assessment process.

Key Referral Information

The key information¹ outlined below will enable our diagnostic team to triage referrals. We would encourage you to complete the following sections collaboratively with families, in preparation for an appointment with their medical practitioner.

Section 1 – Details of Young Person

Surname:

First Name:

Preferred Name:

Gender:

Preferred Pronoun:

Has the young person previously been assessed for ASD?

☐ Yes ☐ No

¹ Key Information based on recommendations from the Autism CRC National Guidelines - <https://www.autismcrc.com.au/knowledge-centre/resource/national-guideline>

If yes – what was the outcome of this assessment?

Can you, the young person, their parent or caregiver provide documents relating to the previous assessment (e.g. who, when, where, assessments administered, diagnostic outcome) ☐ Yes ☐ No ☐ N/A

Can you, the young person their caregiver provide written information (e.g., school reports, previous assessments), to support this referral? ☐ Yes ☐ No

Is there an informant who can provide a developmental history for this young person? (If no, please do not proceed until there is an available developmental informant) ☐ Yes ☐ No

Section 2 – ASD Related Signs and/or Symptoms

Some of the key signs and/or symptoms of ASD in adolescents and adults are listed below. This is intended to provide guidance about commonly reported signs and/or symptoms of ASD for this age group and is not an exhaustive list. Under each heading, please comment on any signs and/or symptoms that you have observed or that have been reported to you about the young person.

1. Please provide examples of current and/or childhood difficulties the young person has with **Social Interaction**, e.g. conversational difficulties, reduced understanding of friendship or other relationships, reduced awareness of socially expected behaviour, difficulty making and maintaining friendships, social isolation and apparent preference for being alone, difficulty understanding social situations.

2. Please provide examples of current and/or childhood difficulties the young person has with **Nonverbal Communication**, e.g. reduced, atypical, or poorly integrated use of gestures and facial expressions, reduced ability to read and interpret others' nonverbal cues (e.g. tone of voice, facial expressions), absent, reduced, or atypical use of eye contact, monotonous tone.

3. Please provide examples of current and/or childhood difficulties the young person has with **Restricted and Repetitive** Behaviours, e.g., hand flapping, spinning and finger flicking, resistance to change, highly specific interests or hobbies, restricted range of interests, literal thinking, strong adherence to familiar routines, echolalia, repetitive speech.

4. Please provide examples of current and/or childhood difficulties the young person has with **Sensory Processing**, e.g. over- or under-sensitivity to touch, smell, taste, noise, or pain

Section 3 – School and Education History

1. Please describe current or previous difficulties obtaining, attending or sustaining education:

2. Please describe the young person's level of functioning at school:

3. Please describe the school-based supports that have been implemented for the young person:

4. Please tell us anything else that you would like us to know about the young person:

If you have any questions about the information provided in this booklet please do not hesitate to contact the clinic coordinator at **(08) 9489 8900** or email: youthadult.diagnosis@autism.org.au