**GUIDANCE ON MAKING A REQUEST TO THE NEURODEVELOPMENTAL ASSESSMENT SERVICE (NDAS)**

NDAS provides an assessment process and diagnostic pathway. While understanding and access to support and intervention can be enhanced by diagnosis, any functional needs should be addressed through the staged approach and child’s plan process and not wait for a diagnosis. If you feel that the child or young person (CYP) requires support or intervention a request for assistance can be made to the relevant service e.g. Speech and Language Therapy (SLT), Occupational Therapy (OT), School Nursing, Primary Mental Health Work (PMHW), Child and Adolescent Mental Health Service (CAMHS), Educational Psychology (EP), etc. at any time. Support information is available at [www.thepineshighland.com](http://www.thepineshighland.com) , [www.thrivingfamilies.org.uk](http://www.thrivingfamilies.org.uk) , <https://bumps2bairns.com/> , or by calling ‘Just Ask’ on 0300 303 1365 any Tuesday or Thursday between 1pm - 4pm.

Additional factors can influence how a CYP presents and must be taken into account when considering a request to NDAS including-

* Medical conditions and mental health concerns
* Learning profile and any specific areas of difficulty such as dyslexia
* Impact of early life experiences and environment and opportunities to develop

Previous support and intervention from OT, SLT, PMHW etc can help inform the NDAS process.

Neurodevelopmental differences/difficulties often over-lap and differential diagnosis may not be appropriate until after age 6. This applies more specifically to Attention Deficit/Hyperactivity Disorder (ADHD) and /or Developmental Coordination Disorder (DCD).

Where possible, CYP of any age, but particularly teenagers, should be involved in decisions about the need and timing of a request to NDAS. The role of NDAS and any concerns should be discussed, and informed consent obtained **before** a request is made to the service.

**Please refer to the following checklist to help guide your decision making when considering and making a request to NDAS, ensuring that you have considered each point before submitting your request.**

|  |  |  |
| --- | --- | --- |
|  | **Is the CYP known to Community Paediatrics/SLT/OT/CAMHS?**  If so, any concerns should be discussed with them in the first instance.  If they feel an assessment within NDAS is in the best interests of the CYP and their family the request to NDAS should come through them |  |
|  | **Is the CYP within the acceptable age range?**  CYP must be over 2.5 years for a request to be considered.  ADHD/ DCD- CYP must be 6+ years, with 1+ years school experience (if relevant), and difficulties cannot be explained by their level of learning. |  |
|  | **Has a staged approach with support been put in place?** |  |
|  | **Have you considered how the following impacts on how the CYP presents?** | |
| * Impact of learning and developmental age and stage |  |
| * Impact of early life experiences and environment and opportunities to develop |  |
| * Impact of medical conditions or mental health concerns |  |
| * The views of the CYP and family |  |
|  | **Has consultation with educational psychology taken place? Please note if this has not been possible.** |  |
|  | **Has the request for assessment been discussed with the Named person/ Lead professional?** |  |
|  | **Has the NDAS Parent/CYP Leaflet been given to CYP and family?** |  |
|  | **Has the consent form been signed by parent/guardian and young person** (if has capacity)?  Please ensure that the parent/guardian making the request has parental rights |  |
|  | **Has the initial Information form been completed in full?** |  |
|  | **Has information on development / learning been included?**  **e.g., Pre-school –** SOGS/ASQ/Developmental Overview **School** – SNAS/BPVS/Dyslexia Profile/CfE Level  If no concerns, please state this. |  |
|  | **Has the Childs Plan been attached?** |  |

**INITIAL INFORMATION & CONSENT FORM**

Please use this form to request assessment from NDAS. Give as much clear information as possible, to enable us to ensure the most appropriate clinicians carry out the assessment.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First Name/Known As** | | | **Surname** | | |
| **Date of Birth** | **CHI** | | **Gender identity:**  **Preferred Pronouns:** | | |
| **Home Address** |  | | | | |
| **Parent/Carer’s Name and Address** (if different from home address) |  | | | **Parental Responsibility**  **YES /NO** | |
| **Phone Number(s) and email** |  | | | | |
| **Parent’s/Carer’s Name and Address** (if different from home address) |  | | | **Parental Responsibility**  **YES /NO** | |
| **Phone Number(s) and email** |  | | | | |
| **GP Name and Address** |  | | | | |
| **Professionals Involved**  Please circle all that apply and note name(s) | **e.g. OT/ SLT/ Community Paediatrics/ CAMHS/ PMHW/ Social Work/ EP** | | | | |
| **Named Person/Lead Prof.** Name, address, role |  | | | | |
| **Interrupted Learner** | Yes / No **Circle which-** Armed Forces/CEYP/Home Schooled/Travellers/Other  **Date likely to move out of area, if known/ applicable-** | | | | |
| **Is/ was known to the Police?** | Yes/ No **Brief details-** | | | | |
| **Interpreter needed?** | Yes/ No **Language Spoken -** | | | | |
| **School/Early Years Setting** | | | | | |
| **Email** | | **Phone** | | | **Year group** |
| **Relevant Medical History (e.g. Vision, Hearing)** | | | | | |
| **Relevant Social History** | | | | | |

**This request for assessment was discussed and agreed with parent(s)/guardian(s)/young person on \_\_\_\_\_\_\_\_\_\_\_\_** **This form was completed by:**

* **Name and role \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Name and role \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **WHAT ARE YOUR CURRENT CONCERNS?** | | | | |
|  | | | | |
| If the child is pre-school or under 5 years old is there a history of regression or developmental delay in two or more areas **YES/NO** | | | | |
| |  | | --- | | **WHICH NEURODEVELOPMENTAL DISORDERS ARE YOU CONCERNED ABOUT?** | | | | | |
| **COMPARISON WITH SCHOOL PEERS (FOR SCHOOL TO COMPLETE)** Please indicate the best description | | | | |
|  | Better than Peers | Similar to Peers | More difficulty than Peers | Significant Difficulties |
| Independence Skills |  |  |  |  |
| Motor Skills |  |  |  |  |
| Communication/ Social Interaction/ Social Communication skills |  |  |  |  |
| Play / Flexible Thinking (adapting to changes) |  |  |  |  |
| Sensory/ Regulation |  |  |  |  |
| Academic/ Learning |  |  |  |  |
| Attention/ Memory/ Organisation and Planning skills |  |  |  |  |
| Emotional Wellbeing/ Mental Health |  |  |  |  |

The rest of this form asks you to provide further details about the areas you have identified above as being more challenging for the child/ young person. **PLEASE COMPLETE ALL RELEVANT SECTIONS OF CONCERN AS FULLY AS POSSIBLE. INCOMPLETE FORMS WILL BE RETURNED WHICH WILL RESULT IN DELAYS.**

Please indicate impact number by highlighting or making bold or circling relevant number. Referrals without impact scoring will be returned for completion. If there is no evidence from your contact with the child that they have the problems listed, write N/A. However please comment on the child’s usual behaviour if you are unsure.

**For each area you identify, you must provide written examples in the boxes below.**

We need very detailed information about a range of behaviours so that we can give the correct assessment. The information from home and school is equally important, even where children only show difficulties in one of these settings. We may still offer a neurodevelopmental assessment as long as there are symptoms in either setting. If you have information that is not covered by the form, please add it on another page. If parents and school prefer to complete on separate forms that is acceptable as long as information is available from both settings.

This form is not for a CAMHS referral.

|  |  |  |
| --- | --- | --- |
| **INDEPENDENCE SKILLS** | | |
|  | Parent/Carer/Young Person Observations | Observations from Early Years Setting/School |
| Dressing, including buttons, zips, changing for PE |  |  |
| Using cutlery, Eating, Drinking |  |  |
| Toileting difficulties |  |  |
| Personal Care e.g. tooth brushing, bathing, showering |  |  |
| Safety issues |  |  |

**Impact at Home** –

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **MOTOR SKILLS** | | |
|  | Parent/Carer/Young Person Observations | Observations from Early Years Setting/School |
| Gross motor skills e.g., Walking, running, hopping, ball skills, jumping, riding a bike |  |  |
| Spatial Awareness – bumping into things, falling over, clumsiness |  |  |
| Fine motor skills – handwriting, drawing, using scissors |  |  |
| Frustration in ability to do the task |  |  |

**Impact at Home** – Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **COMMUNICATION/ SOCIAL INTERACTION/ SOCIAL COMMUNICATION SKILLS** | | |
|  | Parent/ Carer/Young Person Observations | Observations from Early Years Setting/School |
| Current level of spoken language (e.g. no spoken language, single words, sentences) |  |  |
| Does the child understand what you say (Please give examples) |  |  |
| Speech sound production |  |  |
| Volume and tone of voice, fluency, use of accents |  |  |
| Ability to initiate and sustain a conversation with peers/adults |  |  |
| Use of nonverbal communication e.g. gesture, eye contact, facial expression, pointing |  |  |
| Making and keeping friends |  |  |
| Participating in group activities |  |  |
| Understanding and responding to social cues |  |  |
| Understanding and responding to the feelings of others |  |  |

**Impact at Home** –

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **PLAY / FLEXIBILE THINKING** | | |
|  | Parent/ Carer/Young Person Observations | Observations from Early Years Setting/School |
| Play skills (as expected for age) |  |  |
| Play/ Shared interests with other children/ young people |  |  |
| Awareness of others |  |  |
| Imaginative Play / Creativity in activities e.g. story writing, art |  |  |
| Games involving groups of children which require cooperation and turn taking/sharing |  |  |
| Insistence on doing anything the same way each time i.e. routines |  |  |
| Insistence that other children do what he/she says? (Rigidity of thought) |  |  |
| Listen and act upon other people’s suggestions? (Own agenda) |  |  |
| Preoccupation with something which would not interest most other children |  |  |
| What things is he/she good at? |  |  |
| What does he/ she enjoy doing? Do they have a range of interests? |  |  |

**Impact at Home** –

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **SENSORY/REGULATION** | | |
|  | Parent/Carer/Young Person Observations | Observations from Early Years Setting/ School |
| Sensitivity to noises, textures, touch, smell, movement |  |  |
| Difficulty being aware of environment around them – classroom/ traffic |  |  |
| Difficulty coping after a school day |  |  |
| Inappropriately active or inactive in response to what’s going on around them |  |  |
| Food – presentation, texture, restricted diet |  |  |
| Over/under sensitivity to pain |  |  |
| Physical contact- seeks out movement / fidget/ bumps into you |  |  |
| Self-stimulation e.g. rocking, spinning, flapping |  |  |
| Over reactive to small detail e.g. a toy missing, a teacher comment |  |  |
| Emotionally charged/ on alert |  |  |

**Impact at Home** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **ACADEMIC & LEARNING** | | |
|  | Parent/ Carer/Young Person Observations | Observations from Early Years Setting/School |
| Motivation |  |  |
| Discrepancy between verbal ability and recording of work |  |  |
| Homework |  |  |
| Variability of presentation of work |  |  |
| Literacy – reading/spelling |  |  |
| Literacy - writing |  |  |
| Numeracy – particularly sequencing, reasoning and calculation |  |  |
| General knowledge |  |  |
| Do you think he/she is underachieving for their ability? |  |  |
| Please provide information about his/her attainments and progress in relation to their peer group. **\*** |  |  |
| **\* Please attach any relevant documentation (e.g. preschool developmental overview, INCAS, SOSCAS, Curriculum for excellence levels)** | | |

**Impact at Home** –

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **ATTENTION, MEMORY, ORGANISATION & PLANNING SKILLS** | | |
|  | Parent/ Carer/Young Person Observations | Observations from Early Years Setting/School |
| Careless mistakes in schoolwork |  |  |
| Sustaining attention in activities |  |  |
| Listening |  |  |
| Easily distracted |  |  |
| Forgetful |  |  |
| Poor concentration |  |  |
| Hyperactive/Impulsive – fidgeting, leaving seat, “on the go”, blurts out answers |  |  |
| Losing things |  |  |
| Following instructions |  |  |
| Ability to plan and carry out tasks |  |  |

**Impact at Home** –

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**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **EMOTIONAL WELLBEING / MENTAL HEALTH** | | |
|  | Parent/ Carer/Young Person Observations | Observations from Early Years Setting/School |
| Sleep Difficulties |  |  |
| Eating problems |  |  |
| Anxiety |  |  |
| Self Esteem |  |  |
| Tiredness |  |  |
| Signs of frustration, tears, anger |  |  |
| Withdrawn |  |  |
| Confidence |  |  |
| Phobias |  |  |
| Self-Harm |  |  |
| Obsessive behaviour |  |  |
| Low mood |  |  |
| Distress |  |  |
| Relationship difficulties |  |  |

**Impact at Home** –

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**Impact at School** -

Minimal impact 0-----1-----2-----3-----4-----5------6-----7-----8------9-----10 Significant Impact

|  |  |  |
| --- | --- | --- |
| **STRATEGIES** / SUPPORT | | |
|  | Parent/ Carer/Young Person Comments | Observations from Early Years Setting/School |
| Which interventions or strategies have you used to address the child’s difficulties? |  |  |
| What did not work and what has been successful? |  |  |
| What are your views about what can be done to help this  child? |  |  |

**Neurodevelopmental Assessment Service (NDAS)**

**CONSENT FORM**

**Child/ Young person’s name: DOB: CHI number:**

**Please sign/ agree verbally that you understand the following:**

* I/ my child will be assessed and discussed by the Neurodevelopmental Assessment Service (NDAS) team. This may involve a range of professionals (e.g. Speech and Language/ Occupational Therapists, Psychologists, Paediatricians, Psychiatrists, Neurodevelopmental staff).
* Assessment may include questions about my/ my child’s development and/ or a medical examination.
* Anyrelevant information (including written reports) will be shared between NDAS, health, education/early years, and social care professionals as appropriate.
* Assessment may be carried out in different settings and in different ways, e.g. clinic, home, school, early years setting, by video/ phone/ email, completion of questionnaires, etc. This may involve professionals visiting my/ my child’s education/ early years setting to do assessments and consult staff.
* Following assessment, the findings will be discussed with me/ my child and a plan will be agreed.
* Documentation will be kept securely on databases and in written files.

|  |  |
| --- | --- |
| **Please tick all you give consent for-** | |
| Students may observe and participate in assessment and intervention. This will always be under the supervision of the professional involved. |  |
| Audio & visual recordings may be made and used for assessment &/or training purposes |  |
| I/ my child may be withdrawn from early years/ school class for assessment |  |
| The NDAS team may communicate with me by phone (text, voicemail) and/ or email |  |
| Information may be shared with my/ my child’s other parent/ carer. |  |
| Other Click here to enter text. |  |

*The parent/ guardian and child/ young person should give consent when they have capacity to do so.*

*All young people of 12 years + should usually be asked to give consent*. *It is best practice to get written consent.*

**Details of person/ people providing consent:**

**Young person:** Print Name:........................................................ Date & time:............................................... Sign:.......................................................................... / Consent given verbally: Yes / No

**Parent/ Guardian:** Print Name: .................................................Date & time: ................................................ Relationship with child/ young person: ............................................................................................................ Sign: ........................................................................ / Consent given verbally: Yes / No

**Person obtaining consent:** Print Name:................................................... Date & time: ............................... Sign: ........................................................................... Role: ..........................................................................

**Please email to** [**nhsh.nds@nhs.scot**](mailto:nhsh.nds@nhs.scot) **(preferably) ,** or send to: NDAS, The Pines, Drummond Rd, Inverness, IV2 4NZ