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| **Referral Form for****Hospital and Community Teaching Support****Students with EHCP only** |

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| **Referral Information**  |
| Date of Referral |  | Previous Referral Dates |  |  |
| Referrer Name |  | Referrer Role  |  |
| Referrer Email |  | Referrer Contact Number: |  |
| **Personal Information**  |
| Pupil’s name | Date of Birth | NCY | School |
|  |  |  |  |
| Broad area of need – *please indicate what range you consider the child is using ranges document i.e., 4i/4ii* | Communication and Interaction |  |
| Cognition and Learning |  |
| Social, Emotional and Mental Health Difficulties |  |
| Sensory and/or Physical Needs |  |
|  |
| Primary Need | SPLD | MLD | SLD | PMLD | SEMH | SLCN | HI | VI | MSI | PD | ASD | OTH |
| *Please indicate what is the child’s primary need* |  |  |  |  |  |  |  |  |  |  |  |  |
|  |
| Religion |   | Learner’s first language |   |
| Home Address: |  |
| Current Early Help | Yes | No | Current Child in Need | Yes | No |
| Current Social Care | Yes | No | Current Child Protection Plan | Yes | No |
| Child in our Care | Yes | No | Disability Social Worker | Yes | No |
| Siblings (initials only): *learner’s position in family*  |  |
| Early Help/Social Worker Name |  |
| Parent/Carer Name |  | Relationship to child |  |
| Contact Numbers |  | Email: |  |
|  |
| **Education Health and Care Plan**  |
| Date of Last Annual or Interim Review |  |
|  |
| **Please indicate paperwork included with referral: *failure to provide relevant documents may result in referral being returned.***  |
| EHCP  |  |
| Costed Provision Map\* *(must be included for high needs funding requests)* |  |
| Personal Education Plan (PEP) if Child in our Care |  |
| Professional reports |  |
| For Hospital and Community Teaching – *medical evidence from medical professional/consultant confirming pupil is unfit to attend school must be included.* |  |
| Parent and Learner’s Views |  |
| Proof of Parent/Carer Consent via Signature/Email (*we cannot consider the referral if there is not evidence of parental consent and form will be returned to sender).* |  |

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| **Overview of Learner** |
| **Learner Portrait** (please limit to 500 words or less)**Brief history of the Learner and what has happened to cause concern.** **Please detail quality of their relationships both in and outside school where possible.**  |  |
| **What interventions and strategies have been implemented and what was the outcome**?(Insert lines as needed? | Intervention | Frequency | Outcome for Learner |
|  |  |  |
|  |  |  |
| **How would this referral support the Learner?** |  |
|  |
| **Medical and/or Health Factors** |
| **Does the Learner have a diagnosed disability?** If yes, please give details: | Yes |  | Details: |
| No |  |
| **Do you have concerns that the Learner may have social communication needs?** If yes, please give details: | Yes |  | Details: |
| No |  |
| **Is the Learner on the Neuro pathway?** | Yes |  | Details: |
| No |  |
| **Does the Learner have a diagnosis of any of the following?** | PDD-NOS | Yes  |  | Date diagnosed: |
| No |  |
| Autism | Yes |  | Date diagnosed: |
| No |  |
| Asperger’s Syndrome | Yes |  | Date diagnosed: |
| No |  |
| **Do you have concerns about the Learner’s vision?** If yes, give details if they wear glasses and/or your concerns. | Yes |  | **Details** (*please include information of any recent eye test*): |
| No |  | **Detail any STARS involvement**:  |
| **Do you have concerns about the Learner’s hearing?** If yes, give details if they have had a recent hearing test and/or our concerns. | Yes |  | **Details** (*please include information of any recent hearing test):* |
| No |  | **Detail any STARS involvement:** |
| **Are there any other medical conditions?** | Yes |  | Details: |
| No |  |
| **Please indicate where there are concerns with any of the following:** |
| Reading Accuracy |  | Reading Comprehension |  |
| Spelling |  | Short Term/Long Term Memory |  |
| Understanding of Verbal Language |  | Understanding of Non-Verbal Language |  |
| Handwriting |  | Processing Speed |  |
| Attention |  | Numeracy |  |
| Any other (please specify) |
| **Current Academic Ability and Academic Levels including current and target achievement** |
| **Primary** |
| **Early Learning Goals** | Achieved |  |
| Not achieved |  |
|  |  |  |  |  |
| **Year 1 Phonics** | Passed |  |
| Failed |  |
|  |
| **Current****Attainment** | Subject | Higher | Expected | Below  |
| Mathematics |  |  |  |
| Reading |  |  |  |
| Writing |  |  |  |
| Spelling, Punctuation and Grammar |  |  |  |
| **Secondary** |
| **Results of Key Stage 2 SATS** | Subject |  |
| Mathematics |  |
| Reading |  |
| Writing |  |
| Spelling, Punctuation and Grammar |  |
|  |
| **Current** **Attainment** | Subject | Higher | Expected | Below |
| Mathematics |  |  |  |
| English |  |  |  |
| Science |  |  |  |
|  |
| **End of KS4** | Subject | Target | Achieving |
| Mathematics |  |  |
| English Language |  |  |
| English Literature |  |  |
| Science |  |  |

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| **Learner’s Attendance and Exclusion details** |
| Attendance in Current Academic Year (%) |   | Attendance in Last Academic Year (%) |  |
| Suspensions  | Total number of suspensions in current school year |  |
| Total number of days of suspensions in last 2 years |  |
| Permanent Exclusion | Date:Details:Previous School: |
| Has the Learner had any of the following: |
| A respite place in another school | School  |
| Date |
| A managed move to another school | School |
| Date |
| Involvement from the Inclusion Service | Start date |  | End date |  |
|  | Details of Inclusion support: |

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| **Learner’s Care Arrangements** |
| **Is the Learner a Young Carer?** *If yes, please give details i.e. are they supported by Young Carer team.:* | Yes |  | Details:  |
| No |  |
| **Is the Learner a Child in our Care?** | Yes |  | Details:  |
| No |  |
| **Does the Learner have a Care Order?** If yes, please give details: | Yes |  | Details:  |
| No |  |
| **Has the Learner ever been a Child in our Care/Looked after Child?** *If yes, please give details:* | Yes |  | Details: |
| No |  |
| **Does the Learner have a Special Guardianship Order?** *If yes, please give details:* | Yes |  | Details:  |
| No |  |
|  |  |  |  |
| **Other Services/Agencies** |
| **Service/Agency** | **Indicate if involved within last 2 years** | **Indicate if report attached** | **Service/Agency** | **Indicate if involved within last 2 years** | **Indicate if report attached** |
| Educational Psychologist (incl. private assessment) |  |  | CAMHS- Getting Help/Getting More Help |  |  |
| Educational Psychologist –Adults First |  |  | CAMHS -Neuro pathway |  |  |
| STS- ASD |  |  | Mental Health Team in School |  |  |
| STS-Cognition and Learning |  |  | Health Visitor/School Nurse |  |  |
| STS- SEMH |  |  | Occupational Therapy |  |  |
| Inclusion Team |  |  | Health Practitioner |  |  |
| Police |  |  | STARS – sensory teaching advisory service |  |  |
| EWS |  |  | Diabetic Nurse |  |  |
| PREVENT |  |  | Early Years SEND Practitioner |  |  |
| Vulnerable, Exploited, Missing Trafficked (VEMT) |  |  | Resettlement Team |  |  |
| Anti-Social Behaviour Team |  |  | Youth Justice Service |  |  |
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| **Parent/Carer and Learner’s Views and Wishes** |
| **Parents/Carer’s Views and Wishes**: |
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| **Learner’s Views and Wishes:** |
|  |
| **Family and Social/Environmental Factors:** |
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| **Consent statement for information storage and information sharing** |
| Please explain the aim of the referral for Hospital and Community Teaching support to parents/carers before asking them to sign below and what the outcomes from panel may mean for their child. *(Please be aware that without consent signatures the referral will be returned).*I / We understand this information is confidential and will be circulated only to panel members and discussed at the Multi-agency Health and Care Panel. I/We understand that the referral and information will be stored by the local authority for the necessary retention period only. I / We agree to the information in this referral being shared with relevant agencies. I/We understand that my child may be considered for statutory assessment if recommended by panel.  |
| Name of Practitioner (Home School) |  | Signature:  |  | Date: |  |
| Name of Parent/Guardian |  | Signature: |  | Date: |  |
| Name of Young Person:  |  | Signature; |  | Date: |  |

*Please note not filling out the required sections or not attaching the required documentation without robust reason will mean the referral* ***will not*** *be accepted – please review the check sheet at the front of form. Paperwork will be sent back to the referrer with a request to complete fully and return. This may result in a delay for the subsequent panel meeting.*

Please submit completed form and supporting paperwork to the link below

**sen@redcar-cleveland.gov.uk**