**CHS Referral Form**

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| Section A: Personal Details | | | | | | | | | | | |
| Full name of pupil needing support: | |  | | | | | DOB: |  |  | |  |
| Name known as: |  | | M: | | F: | Prefer to self identify (please specify): | | | | | |
| Address: | |  | | | | | | Postcode: | |  | |
|  | | | | | |
| Name of Parent/Carer: | |  | | | | | |  | |  | |
| Address: | | (if different to above) | | | | | |  | |  | |
| Email: | |  | | | | | |  | |  | |
| Contact no: | | Mobile: | | | | | |  | |  | |
|  | |  | |  | | | | | | | |

| Referrer Information | | | | |
| --- | --- | --- | --- | --- |
| Full Name: |  | |  |  |
| Designation: |  | |  |  |
| Organisation: |  | |  |  |
| Contact no: |  | |  |  |
| Email: |  | |  |  |
| Referred by (please tick): | | | | |
|  | | | | |
| Education (EWS/AIO) | |  | | |
| Health | |  | | |
| Other/Assessment/MDT | |  | | |
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| **Please use the table below to see the information required from each type of referrer for each section:** | |
| **Referrer if you are from:** |  |
| **Education**  **(Via EWS / AIO)** | **A**, **B**, **C**, **D**, **E**, **F** (Provide Written Evidence), **G** (If relevant) and **H**  Complete signatures and include the below attachments:   * Attendance printout * Supporting medical information * Baseline information |
| **Health** | **A**, **B** (If known), **C**, **D**, **F** and **H**  Complete signatures and include the below attachments:   * Health Care plan   Alternatively send letters or copies of notes that provide information required |
| **Other, including referral for assessment** | **A**, **B**, **C**, **D** and **H**  Complete signatures and include the below attachments:   * Attendance printout * Minutes of latest review/multi-disciplinary meetings that led to the referral * Baseline information |

| Section B: School and Pupil Information | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NCY: | |  | | School name: | | | |  | | | | |  | |
| Named contact in school: | | | | |  | | | |  | | | |  | |
| Designation: | | | | |  | | | |  | | | |  | |
| Contact no: | | | | |  | | | |  | | | |  | |
| Email: | | | | |  | | | |  | | | |  | |
| UPN:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ULN:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ethnicity:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_ EAL:  Pupil Premium:  Free school meals: | | | | | | | | | | | | | | |
| EHCP | Undergoing EHCP assessment | | SEN support | | | LAC | Previously LAC | | | Adopted | Child Protection plan | Child in Need plan | | Current safeguarding concerns |
|  |  | |  | | |  |  | | |  |  |  | |  |
| Attendance for: | | | | | | | | | | | | | | |
| this term (last 6 school weeks) | | | | | | |  | | | | | | | |
| this academic year | | | | | | |  | | | | | | | |
| previous Academic Year | | | | | | |  | | | | | | | |
| comment on attendance | | | | | | |  | | | | | | | |

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| Section C: Reasons for Referral | |
| What are your concerns about this student? |  |
| Relevant family background |  |
| How does this impact on the student? |  |

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| Section D: Ideal Outcomes | |
| What do you hope to gain from this referral? |  |

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| Section E: Education | |
| Describe how the student behaves in school |  |
| How has the school tried to support this student and how successful has each intervention been?  *e.g. reduced timetable, small group teaching, mentoring, meeting and greeting, home visits, 1:1 teaching* |  |
| Please comment on the student strengths and weaknesses:   * *Academic ability and achievements* * *Social skills and relationships* * *Health and emotional well-being* |  |
| NB. Please enclose information about exam modules, expected levels of entry, courses taken, including off-site provision in the table under Curriculum Information | |

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| Section F: Health Support | |
| Which health professionals are supporting the student?  ***Medical evidence / endorsement must be supplied*** |  |
| What support and therapies are in place or planned for this student? |  |
| Has the student got a care plan from a medical professional? | Yes/No  Please state reason:  NB. A copy of the care/action plan must be enclosed with this referral |
| Does the student have a school Individual Health Care plan? (Both physical and mental medical needs warrant a plan) | Yes/No  If no, then should a plan be written and implemented before a referral request is considered/submitted?  NB. A copy of the medical/action plan must be enclosed with this referral |
| Does the student have any additional health needs/requirements? |  |

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| Section G: Other Agencies | |
| Which other agencies are involved and reasons for involvement? |  |
| What support is in place or planned for this student? |  |

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| Section H: Parents and Carers | | | | |
| What are the views of the parents and student? |  | | | |
| **PARENT CONSENT** –  PARENTS ARE AWARE OF THIS REFERRAL AND:   1. Have given permission for the Children’s Hospital School to contact them. 2. For the Children’s Hospital School to consult with Educational Psychologist, School Medical Officer/GP and other Professionals. 3. Will ensure that their child engages fully in the educational provision made by the Children’s Hospital School. | | Parent/Carer  Print Name: |  | |
| Parent/Carer  Signature: |  | |
| Date: | |  |

| Baseline Information | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student Full Name: | |  | | | | Date: | |  |
| School Name: | |  | | | | | | |
| Please circle relevant boxes below: | | | | | | | | |
| Attendance in last 6 school weeks | >50% | | 25-50% | 10-25% | <10% | | 0% | |
| Timetable | Timetabled for all subjects | | Timetabled for most subject classes | Timetabled for less than 4 subject classes for | Timetabled for  1 or 2 classes | | Not expected to attend classes | |
| Independence in lessons | Is independent in class | | Some accommodations made by teacher but largely independent | Some adult support in class | Has adult support at all times | | Is not able to attend class even with support | |
| Social times (breaks and lunchtimes) | Mixes with other students well, without support | | Manages social times without support | Manages social times in supported environment | Is supported by staff at social times | | Avoids school at social times | |
| Accessing Lessons | Goes into classrooms for lessons without support | | Accesses classrooms with support | Accesses small group teaching | Accesses 1:1 teaching | | Does not access teaching in school | |
| Friendships | Has a number of good relationships | | Has more than one good relationship with other students | Has one good relationship | Has acquaintances | | Socially isolated | |
| Navigates the school | Can move around school and follow timetable independently | | With small accommodations can manage timetable independently | Support required such as meeting and greeting or prompting throughout the day | Substantial support required e.g. accompanied in small part of the school | | Does not move around school | |
| Cooperation | Always cooperative and follows rules | | Small infrequent problems | Some problems, cannot / will not cooperate especially when under stress | General issues with behavior | | Behavioral difficulties | |
| Communication | Communicates well and is polite | | Some difficulties communicating | Often cannot / will not communicate e.g. in class or discussions with staff | Sometimes is inappropriate | | Is often rude and inappropriate | |

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| Curriculum Information | | | | |
| **Subject** | **Current Level/Grade** | **Course (for KS4)** | **Level of Entry** | **Modules completed grade** |
| **English** |  |  |  |  |
| **Maths** |  |  |  |  |
| **Science** |  |  |  |  |
| **ICT** |  |  |  |  |
| **RE** |  |  |  |  |
| **ART** |  |  |  |  |
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| **Please include any other information you feel relevant:** | | | | |
| **Please make sure that all sections are completed in full. Incomplete/missing information may result in a delay.** | | | | |
| **Completed referral form and supporting documents can be sent to the school either:**  **by post - Children’s Hospital School, Willow Bank School, Simmins Crescent, Leicester, LE2 9AH or**  **via email** [**referrals@childrenshospitalschool.leicester.sch.uk**](mailto:referrals@childrenshospitalschool.leicester.sch.uk)  **If you would like to discuss any aspect of the referral process, please contact Elaine Stephens, Review and Referral Administrator on 0116 229 8137 (option 3)** | | | | |