Manchester Hospital School Outreach Referral Form

Please note this form should be typed, not handwritten.

|  | Request for advice – referral form | | | | | | | | | | | |
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| Pupil Details |  | | | | | | | | | | | |
| Full Name |  | | | | | | Date of Birth | | | | |  |
| Preferred Name |  | | | | | | Current Year Group | | | | |  |
| Address |  | | | | | | | | | | | |
|  | | | | | | Post Code | | | |  | |
| Gender | Male ☐ Female☐ Non-Binary ☐ Preferred Pronoun: | | | | | | | | | | | |
| Parent/Carer | Name:  Relationship:  Phone number(s):  Language:  Interpreter required: | | Yes ☐ No ☐ | | | Name:  Relationship:  Phone number(s):  Language:  Interpreter required: | | | | Yes ☐ No ☐ | | |
| Education Details |  | | | | | | | | | | | |
| Date of Referral: |  |  | | | Referred by:  Designation:  Email address: | | |  | | | | |
| Education setting and address: | |  | | |
|  |  |  | | |  | | |  | | | | |
| SEND CoP Stage |  | SEND Support ☐ Statutory Assessment in Progress ☐ EHCP ☐ | | | | | | | | | | |
| Attendance: |  |  | | Pupil at risk of exclusion: | | | | |  | | | |
| Attainment: |  |  | | EHA completed: | | | | | Yes ☐ No ☐ | | | |

| Medical Details | | | | |
| --- | --- | --- | --- | --- |
| Does the pupil have a medical diagnosis?  Please provide details |  | | | |
| Agency involvement – please indicate the other agencies involved with the young person | | | | |
| CAMHS:  Name:  Contact details:  Date: | | Yes ☐ No ☐ | Educational Psychologist:  Name:  Contact details:  Date: | Yes ☐ No ☐ |
| Paediatrician:  Name:  Contact details:  Date: | | Yes ☐ No ☐ | Hospital Consultant:  Name:  Contact details:  Date: | Yes ☐ No ☐ |
| Specialist nurse:  Name:  Contact details:  Date: | | Yes ☐ No ☐ | Sensory Support Service:  Name:  Contact details:  Date: | Yes ☐ No ☐ |
| Speech and Language  Therapist (SaLT):  Name:  Contact details:  Date: | | Yes ☐ No ☐ | Occupational Therapist:  Name:  Contact details:  Date: | Yes ☐ No☐ |
| *Details of concern:* Please describe the reason for the referral | | | | |
|  | | | | |

| *What do you already do to support the Social, Emotional and Mental Health of this young person?* | | | |
| --- | --- | --- | --- |
|  | | | |
| Desired outcomes: please state the desired outcomes of the referral | | | |
|  | | | |
| Consent: | | | |
| Consent must be obtained from parents/carers prior to submitting the referral form.  Please complete and delete as appropriate:  Parents/carers have been given an explanation of the role of this outreach service and the support offered to schools on referral.  Yes ☐ No ☐    Written/verbal consent has been given by parents/carers for the referral to this outreach service including:   * access to existing relevant assessments and reports from other agencies; * access to details of other professionals’ involvement, * attendance at meetings if appropriate, * observation or one-to-one work in school by a member of MHS Outreach Team   Yes ☐ No ☐    It is the school’s responsibility to ensure that parental/carer consent is given for MHS Outreach to be involved with the young person.    Date consent given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Date submitted: |  | Signed: |  |
| Return to MHS Outreach via secure email or password protected word document | | | |
| Leo Kelly Centre, 77 Dickenson Road, Manchester M14 5AZ  Email: office@hospitalschool.manchester.sch.uk Tel: 0161 225 2199 | | | |