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   |