**Medical Advice from Health Professionals**

**Context**

This information is sought in accordance with the Children and Families Act 2014. Advice is being sought as part of an Education, Health and Care Assessment.

**Child/Young Person's Details**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name (s) |       | Surname |       |
| Date of Birth |       | Gender |       |
| Year Group |       | Unique Pupil Number |       |
| Home address |       | NHS Number |       |
| Setting |       | Child Looked After Yes/No |       |
| Ethnicity |       | Religion |       |

**Details of Parent(s) or Person Responsible**

|  |  |  |  |
| --- | --- | --- | --- |
| Name(s) |       |       |       |
| Relationship |       |       |       |
| Home Address |       |       |       |
| Contact Number(s) |       |       |       |
| Email address |       |       |       |
| Preferred method of contact |       |       |       |

**People who support the Child/Young Person**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Role that they play (name of organisation where appropriate) | Email address | Telephone |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

|  |
| --- |
| **PLEASE NOTE: OUTCOMES SECTION** **is on the back page and should be completed by all as required** |

**Service**

Please Tick which service knows the child:

 **✓**

|  |  |  |
| --- | --- | --- |
| * Special School Nursing
 |  |  |
|  |  |  |
| * Occupational Therapy
 |  |  |
|  |  |  |
| * Physiotherapy
 |  |  |
|  |  |  |
| * Speech and Language Therapy
 |  |  |
|  |  |  |
| * CAMHS
 |  |  |
|  |  |  |
| * Child Psychology
 |  |  |
|  |  |  |
| * Community Paediatrics
 |  |  |
|  |  |  |
| * Other consultant (please state)
 |  |  |
|  |  |  |
| * Other (please state)
 |  |  |

Was the child/ young person known to health service beyond universal provision prior to this request?

(Circle as appropriate) Yes No

 (if yes then proceed to section A)

If you are not aware of any needs above those met through the universal offer of health services then please tick this box, sign below and return the form.

Not known to this service and no known needs [ ]

|  |  |
| --- | --- |
| Name | Designation |
|       |       |
| Signature | Date |
|       |       |

**Health/ medical information** *(to be completed by Paediatrician)*

|  |
| --- |
| Health concerns |
|       |

|  |
| --- |
| History |
|       |

|  |
| --- |
| Health Need related to SEND  |
|       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |       |

**Areas of SEN:**

|  |
| --- |
| Communication Interaction *(to be completed by SLT)* |

|  |
| --- |
| Health needs related to SEN      |
| Other health needs      |

|  |  |  |  |
| --- | --- | --- | --- |
| Name      |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |  |

|  |
| --- |
| Cognition and learning *(to be completed by psychology or LD services)* |
| Health needs related to SEN      |
| Other health needs      |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |       |

|  |
| --- |
| Social mental and emotional health *(To be completed by CAMHS / ELCAS / EIS services)* |
| Health needs related to SEN      |
| Other health needs      |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |       |

|  |
| --- |
| Sensory and / or physical needs |

|  |  |
| --- | --- |
| Physical disability *(OT/Physio)* | Health needs related to SEN      |
| Other health needs      |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |       |

|  |  |
| --- | --- |
| Vision *(OT/ ophthalmology)* | Health needs related to SEN      |
| Other health needs      |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |       |

|  |  |
| --- | --- |
| Hearing *(audiology / SaLT)* | Health needs related to SEN      |
| Other health needs      |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |       |

|  |  |
| --- | --- |
| Physical health (Special School Nursing / HV / School Nursing) | Health needs related to SEN      |
| Other health needs      |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Organisation |       |
| Job Title |       | Service |       |
| Qualifications |       | Clinic Address |       |

**Outcomes**

Proposed health outcomes:

List here the outcomes you have agreed with the child and / or family as part of the assessment process and how they will be monitored and achievement defined. Please add in the “Links to area”, the number of the outcome linked areas as show below.

1. Self-Help Skills / Independent Living 2. Social Interaction and friendships 3. Work and future aspirations

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Note the section this links to from the Areas of SEN | Links to area | Proposed outcome | Who will help (describe who will deliver) | Monitoring arrangements  | Define what achievement will look like | Name of author of the outcome |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Authoriser |       | Date of Authorisation |       |
| Signature |       |