**To be completed with or by parents at the time of completing the application for EHCP and included with the application or at the beginning of the term prior to the annual review.**

Child’s Name: DOB:

Address:

NHS number (if known): EHM ID number:

Please tick which local health services **currently** know your child

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  | | --- | --- | | Audiology |  | | Bowel and Bladder/Continence Service |  | | CAMHS/ELCAS/Child Psychology |  | | Community Paediatrician (Please state which hospital) |  | | Continuing Care and Assessment Team/CPOC/Community Specialist Nurses |  | | Dietician |  | | Diabetes Team |  | | Epilepsy Team |  | | General Paediatrician (Please state which hospital) |  | | Learning Disability and Complex Needs Team |  | | Occupational Therapy |  | | Ophthalmology |  | | Orthoptics |  | | Physiotherapy |  | | Special School Nursing |  | | Speech and Language Therapy |  | | Other local consultant (please state) |  | |
|  |
| If under another specialist consultant/team (for example Epilepsy, Endocrinology, Cardiology, gender reassignment or Neurology) or regional specialists/team (for example Manchester, Alder Hey, etc.) please list below: |
| |  |  |  |  | | --- | --- | --- | --- | | Consultant/Nurse Name | Department | Hospital/Trust | Contact Number | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
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