Specialist Advisory Service

Civic Offices

Knoll Street

Cleethorpes

DN35 8LN

Tel: 01472 323314

Email: josephine.cooper@nelincs.gov.uk

**Request for Advice & Support from Specialist Advisory Service**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Pupil Surname** (include names pupil is also known by)**:** |  | **DoB:** |  | **Year Group:** |  | **Gender:** |  |
| **Pupil First Name** (include preferred name if different)**:** |  | **School Attending:** |  |
| **Name of person making referral:** |  | **Position held:** |  |

|  |  |  |
| --- | --- | --- |
| **Which area of specialism is required for this young person?**  | **Date of Referral:** |  |
| Cognition & Learning [ ]  | Speech, Language & [ ] Communication  | Social, Emotional & Mental [ ] Health  |
| Irlen Syndrome Screening [ ]  *If this is all that is required then please include information related to the pupil’s reading and writing difficulties only. Please note that if the young person wears glasses,* ***they must have them*** *on the day of the screening otherwise it cannot be carried out.*  |

**Background**

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| --- | --- | --- |
| Is the young person on the SEND Register? | No [ ]  | Yes [ ]  |
| Does the young person have an EHC Plan?  | No [ ]  | Yes [ ]  |
| Has the young person received school-based SEN support? | No [ ]  | Yes [ ]  |
| Is this young person a Child Looked After?  | No [ ]  | Yes [ ]  |
| Is this young person at risk of permanent exclusion? | No [ ]  | Yes [ ]  |
| Has the young person had a hearing test in the past 2 years?  | No [ ]  | Yes [ ]  |
| Has the young person had a vision test in the past 2 years? | No [ ]  | Yes [ ]  |
| **What was the outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(Recent hearing and vision tests are necessary to ensure the validity of the outcomes of any assessments & if glasses are prescribed then the young person must wear them for the assessments.) |
| **What is the young person’s attendance figure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%** |

**Please provide current and historical progress data AND SEMH Scores (if relevant) from assessments and Review (or attach separately).**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Reading** | **Writing**  | **Maths** | **Date** | **Emotional Aspects** | **Social Awareness and Relationships** | **Independence and Resilience**  | **Behaviour for Learning** |
|  |  |  |  |  | /60 | /60 | /60 | /60 |
|  |  |  |  |  | /60 | /60 | /60 | /60 |
|  |  |  |  |  | /60 | /60 | /60 | /60 |

|  |  |
| --- | --- |
| **Please supply Phonics Screening Score for pupils in Years 1 / 2 or 3:**  | **Please include a scanned piece of the pupil’s unsupported, independent writing.** |

**Which outside agencies have been or are currently involved** (please indicate if still active)**?**

|  |  |  |
| --- | --- | --- |
| Health |[ ]  Social Care  |[ ]  Specialist Advisory Service  |[ ]
| Occupational Therapy |[ ]  Educational Psychology |[ ]  Hearing and Vision |[ ]
| Young Minds Matter (CAMHS) |[ ]  Speech and Language |[ ]  Compass Go |[ ]
| Child Development Centre |[ ]  School Attendance Barriers Team |[ ]  Inclusion Team  |[ ]
| Other, *please specify …………………………………………* |
| *If other professionals are involved, for example, the Educational Psychologist or external agencies such as Compass Go,* ***please ensure they have completed their cycle of work before submitting the referral.*** |

 **What is going well? What are the young person’s strengths?**

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| **Pupil View:****Parent / Carer View:****School View:** |

**What are we worried about? What is not going so well? (Include a summary of the young person’s needs.)**

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| **Pupil View:****Parent / Carer View:****School View:** |

**What are the desired outcomes for the young person? How would you like things to change?**

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| **Pupil View:****Parent / Carer View:****School View:** |

**Please Indicate the Type of Support Required *(please note all timings are approximate)***

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| --- | --- | --- | --- | --- | --- |
|  ½ hour consultation meeting, observation & report (half day)  | [ ]  | ½ hour consultation meeting, observation, Specific Assessment e.g. memory, language, maths & report (3-5 hrs, dependent on assessment) | [ ]  | ½ hour consultation meeting, observation, full cognitive assessment & report (1 day) | [ ]  |
| Feedback meeting following assessments (1hr) | [ ]  | Follow up review meeting (2 hrs)  | [ ]  | Other: |

**Supporting Information**

|  |  |
| --- | --- |
| Are there any other contributory factors: (e.g. medical, social or other barriers to learning?  | *Please include relevant family background e.g. CiN, CP* |
| What additional assessments have been done? E.g. PhAB, DST, Visual stress, SPOT | *What were the results? If preferred attach assessments e.g. SPOT* |
| What support or interventions have been or are in place as part of the Graduated Approach?*If preferred attach the pupil’s My Plan document or similar.* | **Type of support intervention** | **Frequency**  | **Impact** |
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**Please email these forms, via Move It, as Word documents, to**

Josephine.Cooper@nelincs.gov.uk

**Signed parental consent forms may be sent as a pdf document**

**Specialist Advisory Service**

**Parent / Carer Consent Form for Referral & Involvement**

This form is for you to give consent for the Specialist Advisory Service to work with your child and talk to their teachers and helpers.

* Consent will allow the school to share information with members of the Specialist Advisory Service and they in turn may share information with others in their team for advice and guidance.
* Sharing information will allow for professional support and access to research and ideas from colleagues that might otherwise be unavailable.
* Signing this form confirms your agreement to the school asking the Specialist Advisory Service to work with your child by, for example, observing him / her at school, talking to school staff, meeting your child and sometimes working with him/her. Their advice to the school, your child and yourselves will help him/her make progress.
* This form is for parents but can be completed in partnership with school staff.

|  |  |
| --- | --- |
| **Name of Pupil** |  |
| **Date of Birth** |  |
| **School** |  |
| **Parent / Carer** |  |

I give my consent to the request for involvement of the **Specialist Advisory Service** with ………………………and the sharing of information necessary for them to be effective in working with the school and ourselves.

I also give my consent for the sharing of information with other professionals including relevant staff from Health or Social Care.

Names of key professionals currently involved with my child:

Name …………………. Role …………………

Name ………………… Role …………………

**Your consent can be withdrawn, in writing, at any time through the school.**

**Name:……………………………………….(Parent / Carer)**

**Signed ………………………………........(Parent /Carer)**

**Tel No:……………………………………..**

**Email:……………………………………………………………………**

**Date……………………………….........**