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|  **L**ANCASTERIAN **O**UTREACH AND **I**NCLUSION **S**ERVICE**REQUEST FOR ADVICE – REFERRAL FORM** |
| **Pupil Details** |
| **Name of Pupil:** | **Date of Birth:****Gender:**  |
| **Home Address:****Postcode:** | **Home Language:****Interpreter required: Y / N** |
| **Parent / Carer 1 Name**: Relationship to child: Contact Numbers:   | **Parent / Carer 2 Name**: Relationship to child: Contact Numbers:  |
| **Parent / Carer Permissions** |
| ***Consent must be obtained from parents/carers before submitting this referral.***Please complete and circle as appropriate:Parents / carers have been given an explanation of the role of this outreach service and the support offered to schools / settings on referral. **Y / N** Please indicate parental permissions for each statement below:I/ we give my permission for the following: * Access to existing relevant assessments and reports from other agencies **Y / N**
* Access to details of medical professionals’ involvement **Y / N**
* Observation and assessment by LOIS team, if indicated? **Y / N**
* Moving and Handling assessment of your child **Y / N**

The people undertaking the assessment have been trained to complete this assessment this and will liaise with your child’s physiotherapist and/or occupational therapist as appropriate * Assessment for specialist equipment **Y / N**

The people undertaking the assessment have been trained to complete this assessment this and will liaise with your child’s physiotherapist and/or occupational therapist as appropriate It is the school/setting’s responsibility to ensure that parental/carer consent is given for LOIS to be involved with the child. Date consent given: ……………………………………………. Parent / carer signature……………………………………………………….. |
| **Educational Details** |
| **Date of Referral:**  | **Referred by:****Designation:** |
| **Current Setting/School:** | **Year Group:****Class/Form:**  |
| **School / Placement Address:****Postcode:****School / Placement Telephone Number:** | **Head Teacher / Service Leader:****SENCO / Inclusion Co-ordinator:****SENCO’s email address:****Class/Form Teacher:** |
| **SEND CoP Stage (please circle):** SEND Support / Statement in Transition / Statutory Assessment in Progress / EHC Plan |
| **Please refer to and map the pupil on the Manchester Matching Provision to Needs Tool (Physical Disability and Complex Medical / Communication Need) and tick where the pupil lies within the following areas:**

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|  | **Universal** | **Wave 2** | **SEND Support** | **EHC Plan** |
| **Independence and Mobility** |  |  |  |  |
| **Healthcare** |  |  |  |  |
| **Personal Care Needs** |  |  |  |  |
| **Perceptual Skills** |  |  |  |  |
| **Fine Motor Skills** |  |  |  |  |
| **Recording and Physical Access** |  |  |  |  |
| **Communication & Assistive Technology** |  |  |  |  |

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| **Attendance** |
| Pupil is attending school: Fulltime / Part time (state frequency) / Other (state where and frequency) % Attendance at date of referral: |
| **Medical Details** |
| State Diagnosis / Condition(s): |
| State any medication administered ***in school*** including any emergency medication: |
| **Action to Date – Please indicate which services are or have been involved with this child.** |
| **Previous contact with LOIS Y / N**  Contact person: Date: | **Educational /Clinical Psychologist** **Y / N** Name:  Date: |
| **Hospital Consultant(s) Y / N** Name(s): Date: | **Community Paediatrician Y / N** Name: Date: |
| **Specialist Nurse Y / N** Name: Hospital Base: Date: | **School Nurse/Health Visitor (if under 5) Y / N** Name:  Date: |
| **Physiotherapist Y / N** Name:State if Hospital or Community Physiotherapist Date: | **Occupational Therapist (OT) Y / N** Name:  Date: |
| **Speech and Language Therapist (SaLT) Y / N** Name:  Date: | **Sensory Support Service (HI or VI) Y / N** Name:  Date: |
| **What do *you already have in place* to support the physical / medical needs of this pupil?****What have you already tried?** **Please attach any relevant documents to this referral e.g. EHCP, Physio report, HCP.** |
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| **Details of Request: Please tick the current main priority area for which you are requesting advice, support or guidance and complete more details below.**  |
|  | **Request Area from LOIS Core offer** (up to 4 hours per year) **and details of required outcomes** | **Agreed support** (to be completed by Lancs Outreach following initial visit or conversation**)** |
| **Advice** on **managing medical/physical needs** e.g. writing a school-based Individual Healthcare Plan (IHCP), managing daily medication/medical interventions and emergency situations, information about specific conditions, specialist training etc  |  |  |
| **Advice** on **physical access to the school/setting** e.g. mobility needs and equipment, basic seating and posture, risk assessment, off-site trips risk assessment etc |  |  |
| **Advice** on managing **personal care needs** e.g. dressing, toileting and intimate care, accessibility solutions, facilities, policy |  |  |
| **Advice** on **fine motor skill difficulties related to curriculum access** (movements of hands and fingers) and impact of the medical condition e.g. writing and recording, manipulating objects, ICT access for writing and recording |  |  |
| **Advice** on **gross motor skill difficulties related to curriculum access** (movement of lower limbs and wider arm movements) and impact of the medical condition e.g. the PE curriculum, stamina related to standing activities  |  |  |
| Advice on **transition** e.g. to EYFS, to school, to high school, to another school / setting |  |  |
| Other requests (please give details): |  |  |
| **Date submitted:** | **Signed:** |
| **RETURN to the LOIS Team – by secure email**Lancasterian School, Elizabeth Slinger Road, West Didsbury,Manchester, M20 2XA**lois@lancasterian.manchester.sch.uk****0161 445 0123** |