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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:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **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** |  |  |  |  | | | | | | |
| **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** | | | | | |