All sections are mandatory – forms will be returned if not fully completed which **may** delay support

**CONFIDENTIAL**

**REFERRAL FOR SHORT TERM MEDICAL NEEDS EDUCATION PROVISION UNDER SECTION 19**

***Please complete this form using the drop down boxes where appropriate***

***Prior to completion of this form, please answer the following questions:***

1. *Does the CYP have a medical diagnosis?* Choose an item.
2. *Does the CYP have an active current Care Treatment Plan from a Consultant/Medical Professional?* Choose an item.
3. *If you answered yes to Q2, does the plan:*
   1. *confirm and describe the specific medical diagnosis?* Choose an item.
   2. *describe the intervention, duration of input and likely prognosis?* Choose an item.

**If you have answered no to one or more questions, please contact the appropriate Health Professional for further information and/or ensure that a Care Treatment Plan is put in place.**

**If you wish to discuss this further, please email** [**mnhesoffice@bradford.gov.uk**](mailto:mnhesoffice@bradford.gov.uk)

**Date of Referral** Click or tap to enter a date.

**Section 1: Pupil Information**

First Name:

Last Name:

Preferred Name:

Date of Birth: Day: Choose an item. Month: Choose an item. Year:

Year Group: Choose an item.

UPN:

Address:

Postcode:

Gender: Choose an item.

Ethnicity: Choose an item. Other:

Religion: Choose an item. Other:

On roll School:

PP: Choose an item. FSM: Choose an item. LAC: Choose an item.

CP: Choose an item. CIN: Choose an item. Early Help: Choose an item.

Is the CYP known to other Bradford Local Authority Specialist Teaching & Support Services?

Autism Team: Choose an item. Physical Disabilities Team: Choose an item.

Hearing/Visual Impairment Team: Choose an item.

SEMH Team: Choose an item. Resourced Provision Team: Choose an item.

Has the CYP consented to this referral? Choose an item.

**Section 2: Person(s) with Parental Responsibility Information**

Name:

Relationship to CYP: Choose an item. Other:

Address (if different to above):

Postcode:

Telephone No(s):

Email Address:

Name:

Relationship to CYP: Choose an item. Other:

Address (if different to above):

Postcode:

Telephone No(s):

Email Address:

Has the above parent/carer(s) consented to this referral? Choose an item.

***Please be aware that we are unable to proceed without parental consent***

**Section 3: School Information**

School:

Address:

Postcode:

Office Telephone No:

Office Email Address:

**Section 4: Referrer Information**

Name:

Establishment:

Position:

Address (if different from above):

Postcode:

Telephone No:

Email Address:

**Section 5: SEN Information**

Does the CYP have Special Educational Needs? Choose an item.

***If Yes, please complete the section below***

What is the Primary Special Educational Need?

Is there an ECHP in place? Choose an item.

Date of EHCP: Click or tap to enter a date.

When was the last Annual Review? Click or tap to enter a date.

Is there an Annual Review calendared? Choose an item.

Date: Click or tap to enter a date.

Is there an EHCA being processed? Choose an item.

EHCA Submission Date: Click or tap to enter a date.

Does the CYP have school identified SEN Support? Choose an item.

Name of School SENCO:

Telephone No:

Email Address:

Outline how SEN needs are met within school

**Section 6: CSC/LAC Information**

Is the CYP known (now or historically) to CSC? Choose an item.

***If Yes, please complete the section below***

Name of worker:

Establishment:

Position:

Telephone No:

Email Address:

Are there any current safeguarding concerns? Choose an item.

***If Yes, please complete the section below***

Outline safeguarding concerns and how these are being dealt with

**Section 7**: **Other Agency Information (not covered in Section 8)**

Is the CYP known to any other agencies (not covered in Section 8)? Choose an item.

Establishment:

Name of worker:

Position:

Telephone No:

Email Address:

Is the above professional aware of this referral? Choose an item.

Establishment:

Name of worker:

Position:

Telephone No:

Email Address:

Is the above professional aware of this referral? Choose an item.

Establishment:

Name of worker:

Position:

Telephone No:

Email Address:

Is the above professional aware of this referral? Choose an item.

**Section 8: Medical Information**

What is the CYP’s medical need?

How is this medical need prohibiting the CYP from accessing full time school?

Name of medical professional working with CYP:

Establishment:

Position:

Telephone No:

Email Address:

What medical intervention is the CYP accessing? *When? Where? How? Who? What? These will be outlined in the Care Treatment Plan*

How many education hours per week could the CYP be reasonably expected to undertake given the current medical need? Choose an item.

What is the current prognosis? *When will the CYP be expecting to return to full time school?*

Is the above professional aware of this referral? Choose an item.

***Please be aware that we are unable to proceed without medical consent***

**Section 9: School Interventions**

List the strategies that have been used to enable the CYP’s medical needs to be met in school:

If the CYP is not attending school, what education are they currently receiving?

What is in place to ensure that the CYP maintains contact with peers?

What needs to take place to enable the CYP to reintegrate into school?

**Section 10: Background Information**

Give a clear chronological overview of the CYP’s situation that led to this referral:

**Section 11: Attendance**

Date the CYP last attended school: Click or tap to enter a date.

Attendance Percentage for Current Term:

Attendance Percentage for Current Year:

Attendance Percentage for Previous Year:

Name of School Attendance Officer:

Telephone No:

Email Address:

List the strategies that have been used to attempt to maintain the CYP’s attendance at school:

**Section 12: School Data**

|  |  |  |
| --- | --- | --- |
|  | KS1 | KS2 |
| Reading |  |  |
| Writing |  |  |
| Maths |  |  |

Current attainment data:

English:

Maths:

Reading Age:

Other:

Other:

Other:

Add any other information on current attainment:

**Section 13: Examination Information**

Is the CYP due to be taking any national examinations? Choose an item.

***If Yes, please complete the section below***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subject | Board | Qualification | Predicted Grade | Achieved Grade | Coursework completed? |
|  |  |  |  |  | Choose an item. |
|  |  |  |  |  | Choose an item. |
|  |  |  |  |  | Choose an item. |
|  |  |  |  |  | Choose an item. |
|  |  |  |  |  | Choose an item. |
|  |  |  |  |  | Choose an item. |
|  |  |  |  |  | Choose an item. |

Name of School Exams Officer:

Telephone No:

Email Address:

Will the CYP be sitting their examinations at school or have alternative arrangements been put in place? Choose an item.

Give details of any access arrangements in place/needed:

**Section 14: P16 Arrangements**

Is the CYP in Y11? Choose an item.

***If Yes, please complete the section below***

Has a P16 provision been identified? Choose an item.

Which P16 provision has been identified?

If the CYP has an EHCP, has consultation taken place? Choose an item.

Name of School P16 Liaison:

Telephone No:

Email Address:

**Section 15: Secondary School Arrangements**

Is the CYP in Y6? Choose an item.

***If Yes, please complete the section below***

Has a secondary school been identified? Choose an item.

Which secondary school has been identified?

If the CYP has an EHCP, has consultation taken place? Choose an item.

Name of School Y6/7 Transition Liaison:

Telephone No:

Email Address:

**Section 16: Essential Documentation**

*If any of the below documentation is not provided, the processing of this referral* ***may*** *be delayed*

Medical Evidence of Diagnosis (from a health professional)

Care Treatment Plan

EHCA/P/School SEN Information

School Report (including attainment & progress)

Attendance Records (current & previous year)

Risk Assessments (for CYP who may be a risk to themselves or others)

Any other Agency Reports (including CSC)

***Please return this form to*** [***mnhesoffice@bradford.gov.uk***](mailto:mnhesoffice@bradford.gov.uk)

***If the referral is accepted, an Initial Planning Meeting will be called by MNHES and all professionals identified will be invited to attend.***

***Please be aware that a delay in professionals attending the meeting (or sending a written report) may result in a delay in processing the referral.***

***If you have any queries, please contact*** [***mnhesoffice@bradford.gov.uk***](mailto:mnhesoffice@bradford.gov.uk)