**EAIP REFERRAL FORM**

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| **Referral type: Please tick**  **☐ Individual - Complete Sections 1 to 5**  **☐ Group - Complete Section 1 and 6**  **☐ School - Complete Section 1 and 6** |

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| **Section 1: General Information** | | | | | | | |
| **Referral Date:** |  | | **Local Authority:** | | **Kingston ☐ Richmond ☐** | | |
| **Pupil Name:**  (If applicable) |  | | | | | | |
| **DOB:**  (If applicable) |  | | **Year Group:**  (if applicable) | |  | | |
| **Parental permission received?** | **YES** |  | | **NO** | | |  |
| **Admission to school** (full date) |  | | | | | | |
| **School:** |  | | | | | | |
| **School Contact:** | | | | | | | |
| **Name:** |  | | **Job Title:** | | |  | |
| **Email:** |  | | **Phone no:** | | |  | |

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| **Reason for referral: What would you like support with:** |
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| **Section 2: Pupil Concerns** | | | | | |
| **Describe your concerns – what are you seeing?** | | | | | |
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| **Further information regarding specific known learning difficulties or SEN needs:** | | | | | |
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| **☐ SENK** | **☐ EHCP** | | | **☐ Pending** | **☐ None** |
| **Name of SEN Co-ordinator :**  (if applicable) | |  | | | |
| **EAL? Home language:** | |  | | | |
| **Current attendance level %:** | |  | | | |
| **Has this child previously been excluded?** | | | **☐ Yes ☐ No** | | |
| **Approximate dates of exclusion and reasons:** | | | | | |
|  | | | | | |
| **Pupil Premium** | **☐ Yes ☐ No** | | | **Is this child at risk of permanent exclusion?** | **☐ Yes ☐ No** |
| **Has school used:** | | | | | |
| **SEMH/SEN/ASD Surgery Consult?** | **☐ Yes ☐ No** | | | **Threshold Guidance?** | **☐ Yes ☐ No** |
| **Details of all support/interventions/provision offered so far:** | | | | | |
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| **Section 3: Social Care Involvement? YES/ NO**  **(Please provide approximate dates and names of professionals where known):** | | |
| **Child in Need Plan** | **☐ Yes ☐ No** |  |
| **Child Protection Plan** | **☐ Yes ☐ No** |  |
| **Fostered/Adopted** | **☐ Yes ☐ No** |  |
| **Historical: Give details** | **☐ Yes ☐ No** |  |

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| **Section 4:** | | | |
| **Other Service involvement?** | | **Contact details & approximate dates if known:** | |
| **CAMHS Tier 3**  **(Consultant Psychiatrist level)** | |  | |
| **CAMHS Tier 2**  **(Emotional Health Service)** | |  | |
| **Family Support/Strengthening Families** | |  | |
| **Educational Psychology** | |  | |
| **Education Welfare Service** | |  | |
| **Speech and Language Therapy** | |  | |
| **Other (please state)** | |  | |
| **SPA Referrals made by the school:** | | | |
| **Approximate Date** | **Reason** | | **Outcome** |
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| **Section 5: Academic information** | | | | | |
| **PRIMARY:**  **Is this pupil working at expected academic levels?** | | | | | |
| **Maths** | **☐ Yes ☐ No** | | **Details:** | | |
| **Reading** | **☐ Yes ☐ No** | | **Details:** | | |
| **Writing** | **☐ Yes ☐ No** | | **Details:** | | |
| **SECONDARY:**  **Last Assessed Level:** | | **Maths** | | **English** | **Science** |
| **Target Level:** | | **Maths** | | **English** | **Science** |
| **If Secondary age please give previous primary school:** | |  | | | |
| **KS2 SATS Scores:** | |  | | | |

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| **Section 6: Whole School/Group Referrals** |
| **State reason for referral, expectations of support and/or training requirement:** |
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