**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:** |
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| **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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