**Education Inclusion Support Service** 

**EAIP referral form**

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

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| **Section 1: General information**  |
| **Referral date:** |  | **Local authority:** | Kingston [ ] Richmond[ ]  |
| **Pupil name:****(If applicable)** |  | **Pupil Ethnicity (mandatory):*****(4 digit code if known)*** |  |
| **DOB:**(If applicable) |  | **Year group:** (if applicable) |  |
| **Parental Consent:** | Yes ☐ No ☐ | **Admission to school (full date)** |  |
| **School:** |  |
| **School contact:**  |
| **Name:** |  | **Job title:** |  |
| **Email:** |  | **Phone no:** |  |
| **Reason for referral: What support would you like from the EAIP** |
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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 EHCP 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 or 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 and 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 or group referrals** |
| **State reason for referral, expectations of support and/or training requirement:** |
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