**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:** | | | | |
|  | | | | |
| **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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