**Early Advice and Intervention Panel (EAIP) referral form**

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| Use the EAIP referral to access support for pupils with additional needs from the Education Inclusion Support Service (EISS), The Advisory/Outreach Services for children/young people with Autism/social communication needs and the Lead School Improvement Advisor for SEND.  **Completing the right referral?**  Access a quicker pathway to support using the **Remote Consultation Referrals**.  Follow these links:  Education Inclusion Support Service (EISS):  [**EISS Remote Consultation Online Referral Form here**](https://forms.gle/UNuZ88A5HJJ3BKHL6)  Autism Spectrum Disorder (ASD)/Social Communication Needs Consultations Referrals:  [**Kingston Primary Schools**](https://docs.google.com/forms/d/e/1FAIpQLSfjWdbgONdz3mz4DbxbtYBbpfhqSrkcqTDBAJ599VoSnkF7iQ/viewform?usp=sf_link)  [**Richmond Primary Schools**](https://docs.google.com/forms/d/e/1FAIpQLSevzZKGVwyYQs76lZuIE5KUwl55B719zq9AElN078rc2UYXbA/viewform?usp=sf_link)  [**Secondary Schools (Kingston & Richmond)**](https://docs.google.com/forms/d/e/1FAIpQLSdkwMA7-9GmDS31PYAoHruRKIdIGgui49cr6sYdxZhZrtlQqg/viewform?usp=sf_link)  **Referral type: Please tick**  ☐ Remote Consultation - see above  ☐ 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:** |  | | |
| **Pupil name:** |  | | | | |
| **DOB:** |  | **Year group:** |  | | |
| **Parental Consent:** | Yes ☐ No ☐ | **Pupil Ethnicity (mandatory)** |  | | |
| **School:** |  | | | | |
| **Contact name:** |  | | | | |
| **Email:** |  | **Phone no:** | |  | |
| **Reason for referral: (bullet point format)**  **Please advise if/how Covid-19 has had a significant effect on this pupil (if relevant)** | | | | |
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| **What support would you like from the EAIP?** | | | | |
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| **Section 2: Pupil concerns** | | | | |
| **Further information regarding specific known learning difficulties or SEN needs:** | | | | |
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| **What does the pupil say about the current situation?**  *This will be a focus during the consultation.* | | | | |
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| **☐SENK** | ☐**EHCP** | | ☐**Pending** | ☐ **None** |
| **Name of AfC EHCP co-ordinator :**  (if applicable) | |  | | |
| **EAL? Home language:** | |  | | |
| **Current attendance level %:** | |  | | |
| **Has this child previously been excluded?** | | **☐Yes** ☐ **No** | | |
| **If YES, how many times?** | |  | | |
| **Is this child at risk of permanent exclusion?** | ☐**Yes** ☐**No** | | **Pupil Premium** | ☐**Yes** ☐**No** |
| **Details of all support, interventions or provision offered so far:** | | | | |
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| **Section 4:** | |
| **Other service involvement?** | **Please provide approximate dates and names of professionals where known.** |
| **Child in need plan** |  |
| **Child protection plan** |  |
| **Fostered/adopted** |  |
| **Social Services historical: Give details** |  |
| **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)** |  |

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| **Section 5: Academic information** | | |
| **Is this pupil working at expected academic levels?** | | |
| **Maths** | **☐ Yes ☐ No** | **Details:** |
| **Reading** | **☐ Yes ☐ No** | **Details:** |
| **Writing** | **☐ Yes ☐ No** | **Details:** |
| **If secondary age please give name of previous primary school:** |  | |

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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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