**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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