***This form is for Primary schools to request additional support to enable them to understand and meet a child’s needs.***

***This work will be targeted and will be in place for one half term in the first instance.***

***Allocation of support is agreed at the Learning Support Hub each half term***

***The Learning Support Hub Privacy Notice can be found at*** [***https://www.yorksend.org/team-city-york-council/specialist-teaching-team/8***](https://www.yorksend.org/team-city-york-council/specialist-teaching-team/8he)

**FORM TO BE RETURNED TO** [**learningsupporthub@york.gov.uk**](mailto:learningsupporthub@york.gov.uk)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Please tick the boxes below if this is a request for statutory services*** | | | | | | | |
| Deaf and Hearing Support Team  (Referral from audiology) | Visual impairment  (Referral from opthamology) | | | Medical Needs Tuition Service  Referrals can only be accepted with a consultant’s letter which confirms the child/young person is unable to attend school due to ill health. This letter **must** be submitted with the referral form. The letter should include an estimated return or review date | | | |
|  |  | | |  | | | |
|  | | | | | | | |
| ***Please complete all the fields below for all requests*** | | | | | | | |
| **CYP Details** | | | | | | | |
| Child / Young Person’s Name | |  | | | | | |
| Date of Birth | |  | Year Group | |  | **M** | **F** |
| Home Address | |  | | | | | |
| Post Code | |  | | | | | |
| Name of Setting (if applicable) | |  | | | | | |
| Does the child/young person have | | MSP Yes /No | EHCP Yes/No | | EHA Yes/No | CPP Yes/No | |
| Is the child/young person | | Child in Care Y/N | | | | | |
| **The child’s family contact details** | | | | | | | |
| Parents / Carers Name(s) | |  | | | | | |
| Home Telephone Number | |  | Mobile Number(s) | |  | | |
| Email Address | |  | | | | | |
| Family Language | |  | | | Communication Needs | e.g. text only | |
| **Who is making this referral?** | | | | | | | |
| Name | |  | | | | | |
| Position / Role | | SENCo/Headteacher Referrals must be from the SENCo or Headteacher of setting.  Referrals from other staff will not be accepted. | | | | | |
| Setting / School Address | |  | | | | | |
| Telephone Number | |  | | | | | |
| Contact Email Address | |  | | | | | |

|  |  |
| --- | --- |
| **What is the primary need of the child?** |  |
| **What is the reason for this request?**  **Please provide as much information as possible.** | |
|  | |
| **Please describe provision currently in place to meet needs**  Please provide as much information as possible. | |
| ***Description of the desired outcomes*** *from the 6 week intervention – please be SMART* | |
|  | |
|  | |
|  | |
| **Other professionals involved** | |
|  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Attendance** | | | | | | | | | |
| Setting / School Name | | | Academic Year | | | | Attendance % | | |
|  | | |  | | | |  | | |
|  | | |  | | | |  | | |
|  | | |  | | | |  | | |
| **Exclusion Record** | | | | | | | | | |
| Setting / School Name | | | Year | | | | Number of days exclusion | | |
|  | | |  | | | |  | | |
|  | | |  | | | |  | | |
|  | | |  | | | |  | | |
| **Attainment Record** | | | | | | | | | |
|  | | Currently working at | | |  | | | Currently working at | |
| English | |  | | | Maths | | |  | |
| Please include any standardised scores below eg from screener | | | | | | | | | |
|  | | | | | | | | | |
| **Wellcomm completed** | Yes/No | | | **Wellcomm score** | |  | | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Timetable – to support our allocation process, please indicate any days the child does not attend school and/or where there is no TA/SENCO available (where relevant)** | | | | | |
| **Day** | Monday | Tuesday | Wednesday | Thursday | Friday |
| **Time not available** |  |  |  |  |  |

|  |
| --- |
| **Child’s Voice** (should be completed where possible) |
|  |
| **Parent Contribution to referral** (must be completed) |
|  |

**How to submit the referral**

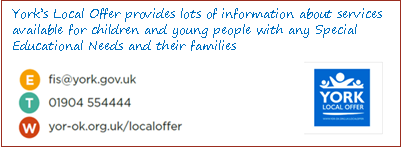
Please return this referral form with any supporting reports, medical letter and the signed parental declaration/statement that shows they understand and/or have had the privacy notice explained to them to: [learningsupporthub@york.gov.uk](file:///\\eldata\education$\GROUP\Specialist_Teaching_Team\LSHub\learningsupporthub@york.gov.uk)

**Request will not be accepted without parental declaration/statement**

|  |  |  |
| --- | --- | --- |
| **I** **confirm that I have read and understood the Learning Support Hub privacy notice and that my personal information will be used as described in it**  **I confirm that the Learning Support Hub privacy notice has been explained to me and that my personal information will be used as described in it** | | |
| **Name** | **Signature** | **Date** |
|  |  |  |
|  |  |  |

**Lead Practitioner has confirmed that signed declaration/statement has been given and will be stored safely and securely in accordance with data protection legislation and their own internal policies and procedures (please tick)**

|  |  |  |
| --- | --- | --- |
| **Lead Practitioner Name** | **Signature** | **Date** |
|  |  |  |

**Information for Parents and Carers:**

Further information about the service is on the Local Offer. <https://www.yor-ok.org.uk/families/Local%20Offer/specialist-teaching-team.htm>

**By signing the declaration / statement you understand that the Learning Support Hub will:**

1. Allocate workers to work with your child in his/her school or setting, in your home or another agreed local setting.
2. Discuss the delivery of interventions to meet agreed outcomes and discuss reintegration planning with professionals from CAMHS and other health and social care professionals when required.
3. Discuss with the Local Area teams, what other support may be available to facilitate meeting outcomes and / or a reintegration back to school where appropriate.
4. Take photographs and / or audio and/or video recordings of your child for record keeping and assessment arrangements. Photographs will not be used for any other purpose without the additional consent of parents / carers (see below).

Please indicate whether you give your consent for your child’s photograph to be taken for the following purposes. No child or young person will be named in the use of these photographs.

|  |  |
| --- | --- |
|  | Consent given |
| For record keeping and assessments including assessments for settings/schools | Yes / No |
| To illustrate the use of a specialist piece of equipment | Yes / No |
| To describe the work of the Learning Support Hub | Yes / No |
| To illustrate a special project or event organised by the Team | Yes / No |

|  |  |
| --- | --- |
| **Name of Parent / Carer** |  |
| **Name of CYP** |  |
| **Signature (Parents)** |  |
| **Signature (Child/Young person – where appropriate)** |  |
| **Date** |  |

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**Glossary of Terms**

CPP – Child protection plan

EHA – Early Help Assessment

EHCP – Education, Health and Care Plan

MSP – My Support Plan