



REFERRAL FORM FOR SPECIALIST LEARNING SUPPORT

Name:	D.O.B: Age:
Address:	Parents/carers:
School:	GP:
Referrer:	Lead professional:
Diagnosis:	Other professionals involved:

Assessment Checklist:

Pre-Panel Assessments	Y/N	Comments	Date Completed/Updated
Continuing Care Assessment (Essential for referral to progress – please attach)			
Statement of Educational need			
Child in Need Plan			
Core Assessment			
“Other” Please Specify			

Main Health Needs:

Medical interventions	Yes/No	Frequency required	Comments
Enteral feeding (e.g. gastrostomy feeding)			
Suction (Oral/naso-pharyngeal)			
Seizures requiring intervention			
Tracheostomy care			
Assisted mechanical ventilation			
Other (please specify)			

School/Early years setting or intended provision:

Attendance record – number of sessions attended over past academic year	
Why current provision is not meeting the child/young person's educational needs	

Summary:

Supporting information	Identified needs including risks
Proposed Plan	Expected Outcome & Timescales

FOR PANEL USE ONLY

Name of child/young person:

Panel decision:

Panel Date:

Agency Representation:

Date referrer informed and by whom:

Date Parent Informed and by whom: