



Families and Wellbeing Directorate
Referral Form – Medical Needs Tuition

All referrals are the responsibility of the school and must come from the school with written evidence of the illness and confirmation of ongoing medical intervention (Part B).

The case cannot be considered until this form has been completed and returned by the school. The medical evidence part of the form must also be completed. (Failure to do so will lead to a delay in any possible provision of service).

The pupil needs to have had an injury, diagnosed illness or an acute episode of mental illness which prevents them from attending school beyond 15 days. **Information on this form will be shared with all professionals working with the pupil.**

School:	Named School contact: Name of School Nurse:
Main School tel no: Direct contact tel no:	Email:
Pupil name:	D.O.B
Year group:	Gender
Current attendance (please attach registration certificate):	Last day attended:
Pupil address:	Contact details: Home: Mobile: Work: Email:
Name of parent/guardian:	Relationship to pupil:
Agencies involved: (please circle) CAMHS Inclusion team YOT School health Housing Other	Social Care; Is the pupil known to social care? Y/N Current support (please circle) FSW CIN CP CIC

Has an IHP (Individual Health Care Plan) been completed? Y/N
(If 'yes' please attach)

Do you receive additional funding from the LA High Needs block? Y/N

Additional Information

Are you aware of any known risks associated with the pupil or their family? Y/N

(If yes please give details)

EHA completion date ___/___/___

Next EHA review date ___/___/___

Has the pupil been identified as having SEN? Y/N

Does the pupil have an EHC plan? Y/N

Reason for referral

Describe the medical condition in detail. Explain why the pupil may experience barriers to learning, participation and progress and would be unable to attend school full time.

List the strategies which have been used by school, to date, to promote sustained attendance and academic progress.

Please outline the schools plan for the continuing education and full reintegration of the pupil.

Academic profile

Current attainment data (please indicate sub levels if appropriate).

English (KS3 – KS4)	
Reading (Reception – KS2)	
Writing (Reception – KS2)	
Maths	
Science	

Expected levels at end of current key stage.

English (KS3 – KS4)	
Reading (Reception – KS2)	
Writing (Reception – KS2)	
Maths	
Science	

For KS4 pupils please list option subjects and target grades.

Subject	Target grade

Where possible please complete this section with the pupil.

<p>Does the pupil attend extra curricular activities or have any hobbies or interests?</p> <p>What are the pupils' favourite subjects?</p>

Parent/Guardian consent

I give my permission for health professionals working with my son/daughter to share medical information with educational professionals by completing part B of this form.

Signed (Parent/Carer) _____

Date _____

Signed (Referrer) _____

Date _____

Position in school _____

Medical Evidence

Part B of this form must be sent for completion, by school, to the appropriate health professional; consultant paediatrician, adolescent psychiatrist, consultant child psychiatrist or hospital consultant. GP evidence alone cannot be accepted. Once part B has been completed both part A and B should be sent to:

Millie Webster
Pupil Support Co-ordinator
Warrington Borough Council
Families and Wellbeing Directorate
2nd Floor
New Town House
Buttermarket Street
Warrington
WA1 2NH

Tel: 01925 446174
Email: millie.webster@warrington.gov.uk

For office use only

Medical tuition agreed? Y/N

Number of hours allocated _____

Tutor name _____

Tuition start date _____