**SPECIALIST EDUCATION SERVICES (SES) REFERRAL FORM**

In line with GDPR regulations, please send this form via an encrypted email (e.g. OME) stating **OFFICIAL-SENSITIVE** in the subject field. ***Signatures will be taken as full permission to progress this referral.***

**Send to:** [**SESReferrals@suffolk.gov.uk**](mailto:SESReferrals@suffolk.gov.uk)Incomplete referrals will be returned.

Please **do not** use this form for referrals for Alternative Provision, Specialist Provision (including Key Stage 1 Specialist Units), Permanent Exclusions, IYFAP and the Alternative Tuition Service (ATS). Please use the Inclusion Referral Form available on the Local Offer.

|  |  |
| --- | --- |
| **Specialist Education Service Request(s)**  **(Appendix must be completed where there is a \*)** | |
| Communication and Interaction |  |
| Speech, Language and Communication Needs |  |
| Cognition and Learning |  |
| Specific Learning Difficulties (formerly DOT) |  |
| Social, Emotional and Mental Health |  |
| Visually Impaired / Hearing Impaired / Dual-Sensory Impaired (Including Intervenor Service) |  |
| \*Specialist Learning Support Service (not available in Lowestoft and Waveney) |  |
| Whole School Inclusion Support (***please only complete Section 7 at the end of this form)*** |  |

**Section 1: Pupil details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname (capitals) | |  | | Forename(s) |  |
| Date of birth |  | Current NCY |  | UPN |  |
| Gender | |  | | | |
| Current education setting | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Address (where currently living) |  | | |
| Postcode |  | Home tel. no. |  |
| Nationality |  | | |
| Home language 1 |  | Ethnicity | Ethnicity. |
| Home language 2 |  |

**Social Care**

|  |  |  |  |
| --- | --- | --- | --- |
| Child in Need |  | Child Protection 0-18 |  |
| Child in Care 0-16 |  | Court of Protection 18+ |  |
| Leaving Care 16+ |  | Adult and Community Services 18+ |  |
| Early Help 0-18 |  | Disabled Children and Young People 18+ |  |

**Child in Care (If applicable)**

|  |  |
| --- | --- |
| If a Child in Care, name of Authority |  |
| Child in Care status |  |
| Social worker |  |

**SEND stage**

|  |  |
| --- | --- |
| SEND Support |  |
| Education Health Care (EHC) Needs Assessment requested |  |
| Education Health Care (EHC) Needs Assessment started |  |
| Education, Health and Care (EHC) Plan |  |

**Additional information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pupil Premium | |  | High Needs Funding Band |  |
| Current attendance: |  | | | |

**Area(s) of need**

|  |  |  |
| --- | --- | --- |
| **Areas of need** (select **only one** primary need) | **Primary** | **Additional** |
| Communication and interaction (including SLCN) |  |  |
| Cognition and learning (including SpLD) |  |  |
| Social, emotional and mental health |  |  |
| Sensory / Physical (i.e *clinically diagnosed sensory loss and* ***not*** *sensory processing or integration difficulties)* |  |  |

|  |
| --- |
| **Does the pupil have any diagnosed conditions?**  **If yes, please specify what, when this was diagnosed and who by.** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment/Attainment Data** | | | |
| Standardised/recognised test scores (include name of test and date of assessment): | | | |
| Other assessments (include date/type of assessment): | | | |
| Current attainment (if pupil is working below age-related expectations, please indicate at what year group the pupil is working at): | | | |
| Please describe the pupil’s academic progress over the last 2 terms. | | | |
| Please indicate attainment at the last national reporting point: | | | |
| GLD | Yes/No | Y1 Phonics /40  Y2 Phonics (retake) |  |
| Y2 SATs | | Y6 SATs | |
|  | |  | |

**Education history**

|  |  |
| --- | --- |
| **Known Previous Schools / Settings / EHE (Elective Home Education)** | **Dates attended** |
|  |  |
|  |  |
|  |  |
|  |  |

**Section 2: Other professionals / services / agencies involved**

**State if any other agencies are currently involved or have been in the last 6 months with this pupil and/or family and provide details of each agency’s key worker.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Key worker name** | **Contact details** | **Date of last contact** |
| Psychology and Therapeutic Services (P&TS) |  |  |  |
| Specialist Education Services (SES) |  |  |  |
| Social Care (Please specify team) |  |  |  |
| Early Help (Please specify team) |  |  |  |
| Suffolk Youth Justice Service |  |  |  |
| Health (Please specify) |  |  |  |
| Mental Health Services (Please specify) |  |  |  |
| Other(s) please list below: |  |  |  |
|  |  |  |  |

**Section 3: Pupil and parent/carer views**

(If this cannot be gained, please explain why.)

|  |  |
| --- | --- |
| **Pupil’s views** | |
| **What is working well?**  **What are your strengths and interests?** |  |
| **What are your concerns? What do you find difficult?**  **What might help?** |  |
| **Parent/Carer views** | |
| **What is working well?**  **What are your child’s strengths and interests?** |  |
| **What are your concerns? What does your child find difficult?**  **What might help?** |  |

**Section 4: School views**

|  |
| --- |
| **Tell us what you understand the pupil’s additional needs to be, how the pupil is presenting and what are your concerns.** |
|  |

|  |  |  |
| --- | --- | --- |
| **Tell us how you have supported the pupil’s needs so far and what impact this has had. Please include dates.** | | |
| Date | Strategies to support needs | Impact |
|  |  |  |

|  |
| --- |
| **What are you hoping this referral will bring?** |
|  |

**Section 5: Referrer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Forename(s) |  | Surname |  |
| Role |  | Telephone |  |
| School or service |  | | |
| Address |  | | |
| Email |  | | |
| Signature |  | Date |  |

**Section 6: Relevant appendices – please tick if included**

|  |  |  |
| --- | --- | --- |
| Appendix 1 [Found here](https://infolink.suffolk.gov.uk/kb5/suffolk/infolink/advice.page?id=lUtCeeISFzQ) | Specialist Learning Support Service |  |

**Please complete details and permissions below.**

**Section 6: Parent / carer details and permissions**

Full name(s) of all persons with legal parental responsibility / carers (with addresses if different) and relationship to the pupil must be provided for this referral to progress.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Surname |  | | Forename(s) | |  | |
| Title |  | | Relationship to child | | |  |
| Address (if different from pupil’s) | | | Parental responsibility? | | | Choose an item. |
|  | | | Telephone |  | | |
| Mobile |  | | |
| Postcode | |  | Email |  | | |
| Home language | |  | Interpreter needed? | YES / NO | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Surname |  | | Forename(s) | |  | |
| Title |  | | Relationship to child | | |  |
| Address (if different from pupil’s) | | | Parental responsibility? | | | Choose an item. |
|  | | | Telephone |  | | |
| Mobile |  | | |
| Postcode | |  | Email |  | | |
| Home language | |  | Interpreter needed? | YES / NO | | |

**Section 7: Parent / carer permissions**

I / We the parent(s) / carer(s) are in agreement with the information included in this form and understand that:

* The referrer may attend a meeting about this pupil on our behalf regarding the information shared in this form.
* Personal information about me / my / our child may be shared with other professionals outside of SES who are, or have been, involved with me / my / our child and seek relevant information from them to decide what additional support or provision may be needed. **Please indicate here any exceptions:**
* Other professionals outside of SES may become involved should this be deemed helpful. **Please indicate here any exceptions:**

**Parent(s) / carer(s) signature**

Typed signatures will not be accepted.

|  |  |  |  |
| --- | --- | --- | --- |
| **I confirm that I have read all the information on this form, including the SCC CYP Privacy notice** <http://www.suffolk.gov.uk/CYPprivacynotice> | | | |
| Signature |  | Date |  |
| Signature |  | Date |  |

**All information contained within this referral form must be shared with the parent(s) / carer(s) and a signature must be obtained.**

**Forms will be returned and not processed until a signature is obtained.**

**Section 8: For Whole School Inclusion Support ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **WHOLE SCHOOL INCLUSION SUPPORT** | | | | |
| **Name of person completing this form** |  | | |
| **Job title/role & Setting** |  | | |
| **Email address** |  | | |
| **Contact number/s** |  | | |
| **Signature** |  | **Date** |  |

|  |
| --- |
| **Please provide below an overview of the area for which you require support. Please give any relevant details or data, or previous involvement with services.** |
|  |