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| Cheshire West & Chester Logo - colour  CHILDREN & YOUNG PEOPLE’S SERVICES |

# REFERRAL FORM – MEDICAL EDUCATION TEAM

# All referrals are the responsibility of the school and must come from the school with written evidence of the illness and confirmation of on-going medical intervention (part B)

# The case cannot be considered, by the Medical Education Team, 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 a 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.**

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| --- | --- | --- | --- | --- | --- | --- |
| **School Name:** | | | | | **Phone number** | |
| **Named School contact for Pupil:** | | | | | | |
| **Named School contact E Mail:** | | **Named School contact**  **phone number:** | | | | |
| **Pupil Name** | | | | | | |
| **Year Group** | **Gender:** | | | **Date of Birth** | | |
| **Current Attendance:**  **(please include registration certificate)** | | **Last Day Attended:** | | | | |
| **Is the pupil Looked After YES / NO**  **Is there a TAF YES / NO**  **(We advise for all medical cases that a TAF should be offered)** | | **Is the pupil in receipt of the following:**    **Free School Pupil**  **Meals Premium** | | | | |
| **Pupil Address:** | | | | | | **GP:** |
| **Name of Parent/Guardian:** | | | **Tel No:** | | | |
| **Email of parent:** | | | | | | |
| **Emergency Contact:** | | | **Emergency Tel:** | | | |
| **Other Agencies Involved:**  **ESAT CAMHS PRU Education Welfare**  **Social**  **YOS Care Other Please specify………………………………**  **Key Worker / Tel No…………………………………………………………………………………………** | | | | | | |

**Reason for Referral**

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| * **Describe the Medical condition with reasons why the pupil may experience barriers to learning, participation and achievement and are not be able to attend school…………..**   **………………………………………………………………………………………………………………….**  **………………………………………………………………………………………………………………….**  **…………………………………………………………………………………………………………………..** |

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| * **List the strategies which have been explored around maintaining this pupil in school…..**   **………………………………………………………………………………………………………………….**  **………………………………………………………………………………………………………………….**  **………………………………………………………………………………………………………………….** |

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| * **Please outline the school’s plan for the continuing education of this pupil…………………**   **………………………………………………………………………………………………………………….**  **………………………………………………………………………………………………………………….**  **………………………………………………………………………………………………………………….** |

**SEN/DISABILITY**

**Does the pupil have an EHCPlan or Statement? YES /NO**

**If yes, please attach a copy.**

**Has the school identified the pupil as having SEN? YES / NO**

**If YES please tick which area of SEN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Cognition and learning** |  |  | **Communication and interaction** |  |
|  |  |  |  |  |
| **Social, Emotional/Mental Health** |  |  | **Sensory / Physical** |  |

**SEN/DISABILITY CONTINUED**

Has the pupil got a disability? YES /NO

Please provide details………………………………………………….................................................

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Has the pupil got additional needs? YES / NO

**Please provide details…………………………………………………………………………………….**

**…………………………………………………………………………………………………………………**

**…………………………………………………………………………………………………………………**

**Please provide the support strategies being used…………………………………………………..**

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For Key Stage 4 pupils please give details of any examinations likely to be taken.

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| --- | --- | --- | --- |
| **Subject** | **Exam Board** | **Date of Exam** | **Predicted Grade** |
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| |  |  | | --- | --- | | **National Curriculum Results /**  **Teacher Assessment** | | | **KS2** | **KS3** | | English | English | | Maths | Maths | | Science | Science | |  |  | | | | |

**It is the schools responsibility to:**

* Make arrangements for providing and marking school work:
* Provide a consistent key worker to lead and attend initial and subsequent review meetings regarding education arrangements.
* Coordinate appropriate meaningful work for the pupil to complete
* Arrange for feedback to be provided from school to the pupil/tutor for work completed as appropriate.
* Facilitate re-integration support as appropriate

**Parental Agreement to share Medical Information**

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……………………………………………………. Date……………..

**Referral made by**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | .......................................................................................................... | | | | |
| **Position in school** | | ........................................ | **Telephone No.** | | ........................................ |
| **School** | .......................................................................................................... | | | | |
| **Signed** | ............................................................. | | **Date** | ........................ | |

**Medical Information (Part B)**

# It is the school’s responsibility to ensure that Part B of this form is sent for completion by the Medical Professional supporting a referral by school. To be returned to the school on completion. The school will then send the completed referral to: Medical Education Team, Business Support Officer, Tarvin Centre, Meadow Close, Tarvin, Chester CH3 8LY.

**(PLEASE NOTE) Medical Evidence**

# Part B of this form must be sent for completion to the appropriate health professional: Consultant Paediatrician, Adolescent Psychiatrist, Consultant Child Psychiatrist or Hospital Consultant. GP evidence alone cannot be accepted.

Please note that, in order for the Medical Education Team to offer a service or to continue to offer a service, there must be written evidence of ongoing medical intervention.The pupil needs to have had an injury, diagnosed illness or a diagnosis of an acute mental health episode. (These pupils should be receiving ongoing intervention from a CAMHs professional)

Name of pupil ......................................................................................... D.O.B. ............................

Medical Condition ………………………………………………………………………………………….

Date of most recent appointment ………………………………………………………………………..

Brief History of Medical Issues……………………………………………………………………………

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Current involvement and interventions and treatment......………………………………………………..

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Future plans for medical intervention / by whom and with timescales…………………………………..

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Is the pupil on any medication? Please give detail………………………………………………………..

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Are there any issues around the safety of the pupil which ought to be known to those working with him/her?

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Please describe the issues which would make it difficult for this pupil to attend school in the conventional context e.g. full time?

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Likely period of absence from school……………………………………………………………………..

It is my professional opinion that the pupil (please tick):

has had an injury/operation which currently prevents them from attending school .

has a diagnosed illness which prevents them from attending school

has a diagnosed illness **but is able** to attend school either part time or full time with

additional support

is experiencing a diagnosed acute mental health episode which prevents them from attending school (These pupils should be receiving ongoing intervention from a CAMHS professional and the CAMHS Manager should counter sign the referral)

is experiencing mental health problems **but is able** to attend school either part time or full time with additional support

Is this student housebound? YES / NO

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed** |  | **Date** |  |
| **Name & Position** |  | | |
| **Contact details** |  | | |

**CAMHS referrals should be counter signed by the team manager**

**CAHMS Team Manager signature……………………………………….. Date………………………..**

**Please print name……………………………………………………………………………………………**

# School should send the completed referral form to:

**Wendy Williams,**

**Medical Education Team**

**(Education Infrastructure – Floor 3, Nicholas House)**

**Cheshire West and Chester Council**

**4 Civic Way**

**Ellesmere Port**

**CH65 0BE**

# Telephone: (01244) 972825

**Email Address medicalneeds@cheshirewestandchester.gov.uk**

**School MUST send copies of this form to: Parents, EWO, appropriate Consultant Community Paediatricians as below:**

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| --- | --- |
| **For pupils registered with GPs in the West Cheshire CCG please send copy to:**  **Dr Howie Isaac, Consultant Community Paediatrician & DMO**  **Kingsway Children’s Centre**  **University of Chester Kingsway Campus**  **Kingsway, Chester, CH2 2LB**  [dmo.wcccg@nhs.net](mailto:dmo.wcccg@nhs.net) | **Northwich & Winsford areas please send the forms to:**  **Consultant Community Paediatrician**  **Wharton Primary Health Care Centre**  **Crook Lane**  **Winsford**  **CW7 3GY** |