**Specialist Support Team**

**Input Request Form**

**Overview**

* **The specialist support team will be working collaboratively with settings and there will be accountability from both sides.**
* **Pupils must be at range 3 or above on the TfC SEND Ranges**
* **We can only accept referrals from educational settings we cannot accept referrals from GP’s, health professionals or parents.**

**Our offer:**

* **We can/will work with other support teams to ensure the best outcomes for the child or young person.**

**Training:**

* **Training opportunities may be identified following a referral to the service. E.g. 1:1 training with SENDCo, whole school training etc.**

**Individual advice:**

* **Opening meeting with parents, teaching assistant/key worker, lead practitioner, teacher or SENDCo.**
* **Up to 3 visits if needed in collaboration with the SENDCo. More support/visits given to high priority cases at support team discretion.**

**SEN Process**

* **We will work in partnership with the school as part of the SEN process.**

**Our requirements:**

* **Detailed evidence of the range the Child or young person is working within and an up to date support plan.**
* **Copy of child’s provision map with reference to SEND notional finance.**
* **SENDCo available for a consultation at each visit.**
* **Access to the classroom**
* **Access to teacher planning.**
* **Specialist support teams outcomes to be embedded in child’s support plan.**
* **Complete feedback/evaluation questionnaire.**
* **SENDCo to cascade advice and strategies to rest of the school where relevant as the services are unable to offer repeat advice.**
* **SENDCo role to ensure that strategies and advice offered by the support team is being implemented within the school.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Specialist Support Team** | | | | **Criteria for referral:** | | | | | **Required for referral** | | **Email Referral to:** | | | | | | | | | | | | |
| **Autism Outreach Team** | | | | **Diagnosis of ASD** | | | | | **SEN Support Plan**  **Parental Consent Form** | | **Julie.casey@columbiagrange.org.uk** | | | | | | | | | | | | |
| **Language & Learning** | | | | **Working at least 2 years behind age related expectations.** | | | | | **llp@sunningdaleschool.com** | | | | | | | | | | | | |
| **Physical Team** | | | |  | | | | |  | | | | | | | | | | | | |
| **Specialist Support Team Referral Form** | | | | | | | | | | | | | | | | | | | | | |
| **Please complete in full. If not enough information is given we will return the form requesting further detail.** | | | | | | | | | | | | | | | | | | | | | |
| **Name of Child/Young Person:** | | | | | | |  | | | | | | | | | | | | | | |
| **Date of Birth and year group:** | | | | |  | | **Date of ASD Diagnosis (if relevant)** | | | | | | |  | | | | | | | |
| **Additional diagnoses** | | | | |  | | **Is pupil aware of diagnosis:** | | | | | | |  | | | | | | | |
| **Language(s) spoken at home:** | | | |  | | | **Is interpreter required** | | | | | | |  | | | | | | | |
| **Name of Parent/Carer:** | | | | | | |  | | | | | | | | | | | | | | |
| **Address:** | | | | | | |  | | | | | | | | | | | | | | |
| **Email:** |  | | | | | | **Tel. Number:** | | | |  | | | | | | | | | | |
| **Please confirm that you have received the consent of the child’s/young person’s parent/carer for this referral** | | | | | | | | | | | | | | **YES** | |  | | | **NO** | |  |
| **Name of School/Nursery/Provision:** | | | | | | |  | | | | | | | | | | | | | | |
| **SENDCo** | | | | | | |  | | | | | | | | | | | | | | |
| **SENDCo email** | | | | | | |  | | | | | | | | | | | | | | |
| **What are the presenting behaviours of the pupil::** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **What range is the pupil at?** | | | | | | | | | | | | | | | | | | | | | |
| **Range 1** | | **Range 2** | | | | **Range 3** | | | **Range 4** | | | **Range 5** | | | | | **Range 6** | | | | |
| **IN RELATION TO THE RANGE THAT THE PUPIL IS AT** | | | | | | | | | | | | | | | | | | | | | |
| **How have their needs been assessed and planned for:** | | | | | | | | | | | | | | | | | | | | | |
| **Range 1** | | | | | | | | | | | | | | | | | | | | | |
| **Range 2** | | | | | | | | | | | | | | | | | | | | | |
| **Range 3** | | | | | | | | | | | | | | | | | | | | | |
| **Range 4** | | | | | | | | | | | | | | | | | | | | | |
| **Range 5** | | | | | | | | | | | | | | | | | | | | | |
| **What is the impact:** | | | | | | | | | | | | | | | | | | | | | |
| **Range 1** | | | | | | | | | | | | | | | | | | | | | |
| **Range 2** | | | | | | | | | | | | | | | | | | | | | |
| **Range 3** | | | | | | | | | | | | | | | | | | | | | |
| **Range 4** | | | | | | | | | | | | | | | | | | | | | |
| **Range 5** | | | | | | | | | | | | | | | | | | | | | |
| **What strategies have been used:** | | | | | | | | | | | | | | | | | | | | | |
| **Range 1** | | | | | | | | | | | | | | | | | | | | | |
| **Range 2** | | | | | | | | | | | | | | | | | | | | | |
| **Range 3** | | | | | | | | | | | | | | | | | | | | | |
| **Range 4** | | | | | | | | | | | | | | | | | | | | | |
| **Range 5** | | | | | | | | | | | | | | | | | | | | | |
| **What is the impact of these strategies:** | | | | | | | | | | | | | | | | | | | | | |
| **Range 1** | | | | | | | | | | | | | | | | | | | | | |
| **Range 2** | | | | | | | | | | | | | | | | | | | | | |
| **Range 3** | | | | | | | | | | | | | | | | | | | | | |
| **Range 4** | | | | | | | | | | | | | | | | | | | | | |
| **Range 5** | | | | | | | | | | | | | | | | | | | | | |
| **Does the child/young person have an EHC Plan?** | | | | | | | | | | | | | **YES** | |  | | | **NO** | |  | |
| **If yes, please briefly state relevant details:** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Has the child / young person been referred to the Autism Outreach Team before?** | | | | | | | | | | | | | **YES** | |  | | | **NO** | |  | |
| **If yes, please briefly state relevant details:** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Professionals involved** e.g. Consultant / Paediatrician / CAMHS/ CYPS/Physiotherapist/  Occupational Therapist / Speech & Language Therapist/ Social Care | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  | Currently involved: | Name: | Email: | | **Educational psychologist** | Y/N |  |  | | **Language and Learning** | Y/N |  |  | | **Portage** | Y/N |  |  | | **Speech & lang. therapist** | Y/N |  |  | | **Behaviour Team** | Y/N |  |  | | **Occupational therapist** | Y/N |  |  | | **Physiotherapy** | Y/N |  |  | | **Quest** | Y/N |  |  | | **Hearing Impaired** | Y/N |  |  | | **Visually Impaired** | Y/N |  |  | | **Social worker** | Y/N |  |  | | **Health visitor** | Y/N |  |  | | **Attendance officer** | Y/N |  |  | | **Paediatrician** | Y/N |  |  | | **CAMHS** | Y/N |  |  | | **CYPS** | Y/N |  |  | | **Other** | Y/N |  |  | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **What training has been provided to the staff in the past in relation to SEN:** | | | | | | |
| **What training has been delivered** | **Who has received the training?** | | **Who has delivered the training** | **Date of the training** | **What was the impact of the training** | |
|  |  | |  |  |  | |
|  |  | |  |  |  | |
|  |  | |  |  |  | |
| **Current Attainment Data:** | | | | | | |
|  | | | | | | |
| **Key Stage Exit Data in relevant areas e.g. EYFS / KS1/ KS2 / KS3 /KS4** | | | | | | |
|  | | | | | | |
| **Specific reason/s for referral:** | | | | | | |
| **Areas of Concern**  Please give details of the aspects of the child’s development, progress or behaviour that are causing concern. | | | | | | |
| **Impact of Concerns**  Please detail the impact of these concerns in school | | | | | | |
| **What specific outcome(s) are you seeking for the child/young person?** | | | | | | |
|  | | | | | | |
| **Name of Referrer:** | |  | | | | |
| **Position/Job Title:** | |  | | | | |
| **Address:** | |  | | | | |
| **Contact Tel. Number:** | |  | | | | |
| **Contact email:** | |  | | | | |
| **Signed:** | |  | | | **Date:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parent Consent Form for Specialist Support Team Input** | | | | | |
| **I/We have read and understood the information contained in this request** | | | | | |
| **Parent/carer signature:**  The declaration *must* be signed by a parent/carer | | |  | | |
| **Parent/carer name:** | | |  | | |
| **Date:** | | |  | | |
| **Relationship to child/young person:** | | |  | | |
| Please note it is assumed that the child/young person named on this form lives at the same address as the parent/carer providing consent. If this is not the case please provide this information below. | | | | | |
| **Address the child/young person lives at:** |  | | | **Address of the parent/carer giving consent:** |  |
| **Name of the parent/carer that the child/young person lives with:** | |  | | | |