

**Referral Form for the Specialist Learning Support Service (SPLSS)** (not available in Lowestoft and Waveney)

This referral form should be used to request the support of SPLSS for individual pupils meeting [NHS continuing care criteria](https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework)

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

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; please see additional information regarding parental signatures in section 6.***

How we will use your data: <http://www.suffolk.gov.uk/CYPprivacynotice>.

**Section 1: Pupil details**

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

|  |  |  |  |
| --- | --- | --- | --- |
| Address (where currently living) including postcode |  | | |
| Contact number(s) for home |  | | |
| Home language 1 |  | Ethnicity | Ethnicity. |
| Home language 2 |  | Nationality |  |

**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: | |  | | | |
| **For referral to the Specialist Learning Support Service the pupil must:** | | | | | |
| Meet the threshold for continuing healthcare Yes/No | | | | | |
| Have complex medical needs and require hourly nursing interventions Yes/No | | | | | |
| Be continually reliant upon technology (see below for examples) Yes/No | | | | | |
| Have one **COMPLEX** needs score met (see below). Yes/No | | | | | |
| A monthly continuing care panel meeting consisting of representation from the NHS and the Local Authority will consider referrals. Referrals will be discussed and a decision agreed at this referral meeting | | | | | |
| For information about whether the pupil meets the threshold for Continuing Healthcare status please contact Charlotte Downing [Charlotte.Downing@wsh.nhs.uk](mailto:Charlotte.Downing@wsh.nhs.uk) | | | | | |

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| --- |
| **Clinical diagnosis details**  (Please provide evidence of medical condition and key health professionals involved) |
|  |
| **Number of significant hospital admissions over the past year and reasons for admission** |
|  |

**HEALTH NEEDS:**

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| --- |
| **BREATHING** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Needs (would not meet SpLSA criteria please refer to school nursing service** [**School Nursing Service**](https://infolink.suffolk.gov.uk/kb5/suffolk/infolink/service.page?id=7kpKLarRBmY) **or Children’s Community Nursing Team** [**Community Children's Nursing Team**](https://infolink.suffolk.gov.uk/kb5/suffolk/infolink/service.page?id=SY3dlykVk8M)**)** | | | |
| CYP requires repositioning to be able to manage secretions effectively. |  | CYP has a tracheostomy but is not at risk in the event of accidental decannulation due to having a patent airway. |  |
| Requires regular chest physiotherapy at home |  | CYP requires mechanical ventilation at night time only or when unwell at home. |  |
| Requires oxygen when unwell at home/hospital. |  |

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| --- | --- | --- | --- |
| **Complex Needs** | | | |
| Pooling of secretions at the back of the throat and difficulty in swallowing requiring constant supervision and oral/naso pharyngeal suction. |  | CYP has a tracheostomy to maintain airway. Requires constant supervision to provide suction or potential emergency management at any time. |  |
| Requires regular and as required chest physiotherapy in school to maximise respiratory function.  **NB**: Eligibility will not be met with this category alone but in conjunction with another priority need |  | CYP cannot breathe unaided for part or all of the 24 hour period and is reliant upon assisted mechanical ventilation. Requires trained support to assess whether mechanical ventilation required at any time. |  |
| Requires continuous oxygen therapy/optiflow or availability of oxygen at all times. |  |

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| **OTHER CONDITIONS** |

|  |  |
| --- | --- |
| **Medical Needs** | |
| CYP has medical condition that requires monitoring and support from school staff trained by health professional, for further advice please contact [School Nursing Service](https://infolink.suffolk.gov.uk/kb5/suffolk/infolink/service.page?id=7kpKLarRBmY) or [Community Children's Nursing Team](https://infolink.suffolk.gov.uk/kb5/suffolk/infolink/service.page?id=SY3dlykVk8M) |  |

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| **Complex Needs** | |
| Has a medical condition that involves dependence on an appropriately trained adult for most or all of the day to monitor and provide medical interventions when necessary and is dependent upon technology (for examples see list below)  *Life threatening skin conditions ( e.g necrotising fasciitis or Epidermolysis bullosa EB) requiring daily and complex interventions*  *Unstable diabetes insipidus requiring constant monitoring and administration of medication* |  |

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| **TECHNOLOGY AND NURSING INTERVENTIONS:**  **Please specify Yes or No if the CYP is reliant upon any of the following technology** (If yes, please specify if this is required in school and the frequency of intervention required) | | | |
|  |  | Is this required during the school day? | How frequently is this required? |
| Tracheostomy  (*please specify type and how often suction required)* | Yes/No |  |  |
| Invasive and non-invasive ventilation | Yes/No |  |  |
| Suction of upper airway (*Please specify type of suction required eg oral suction, nasopharyngeal suction, cough stimulation* | Yes/No |  |  |
| Oxygen therapy | Yes/No |  |  |
| Optiflow – high flow oxygen therapy | Yes/No |  |  |
| Ostomies *i.e. colostomy, ileostomy, vesicostomy* | Yes/No |  |  |
| Other – *please describe e.g. direct jejunal tube* |  |  |  |

**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** |
| Specialist Education Services (SES) other |  |  |  |
| Health (Please specify) |  |  |  |
| Social Care (Please specify team) |  |  |  |
| Early Help (Please specify team) |  |  |  |
| Mental Health Services (Please specify) |  |  |  |
| Early Years |  |  |  |
| 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 – *please ensure school are aware of this referral as a financial contribution is required for this service***

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| --- |
| **Tell us what you understand the pupil’s additional needs to be, how the pupil is presenting and what are your concerns.** |
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| --- |
| **What are you hoping this referral will bring?** |
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**Section 5: Referrer’s details**

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

**Please complete details and permissions below.**

**Section 6: Parent / carer details**

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 | | |

|  |  |
| --- | --- |
| Are any other communication adaptations required for parents/carers? If yes, please describe. | 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.**