**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.**

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| **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 |
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| --- | --- | --- | --- |
|  | 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 |  |  |

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| **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** |
|  |  |  |  |  |
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|  |  |  |  |  |
| **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:** |  |

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| **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:** |  |