



Health Advice Template

Advice for EHC Needs Assessment

from Health Providers

For

(INSERT CHILD/YOUNG PERSON’S NAME)

This form is to be completed and returned to the SEN area office.

Please note that all the information on this form will be copied to the young person,

parents (for those under 16’s) and all agencies directly involved in the education of the child or young person.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Child/Young Person’s personal details | | | | | | | |
| Forename: |  | | | | Surname: |  | |
| DOB: |  | | Gender at birth: | | Male/Female | NHS Number: |  |
| Which gender does the child/young person identify with if different from above?  Or Is the child/young person in process of changing gender? Yes/No | | | | | | | |
| Home Address: |  | | | | | | |
| Tel No: |  | Email: | |  | | | |
| Parent/carer name: |  | | | | | Preferred Contact No. |  |
| GP name & address |  | | | | | GP Phone number: |  |
| *Views and Aspirations* | | | | | | | |
| Child / young person’s views, interests, aspirations | | | | | If CYP is unable to communicate due to age or need, Parent’s/carer’s views, interests, aspirations | | |
|  | | | | |  | | |

|  |
| --- |
| Child or young person’s health history including any medical diagnoses |
|  |

|  |
| --- |
| Health Needs, Outcome/s and Provision  *(Please refer to the Guidance)* |

|  |  |  |  |
| --- | --- | --- | --- |
| Health Outcomes | | | |
| Strengths | | | |
| Needs and how these impact on the child/young person | | | |
| Provision to meet needs  *Please complete a new row for each need* | Who will provide this: | How often: | How/when this will be reviewed |
|  | Who will provide this: | How often: | How/when this will be reviewed |
| *.* | Who will provide this: | How often: | How/when this will be reviewed |

|  |  |  |
| --- | --- | --- |
| Other information  *Please provide any additional relevant evidence or advice* | | |
| See guidance | | |
|  | | |
| Lead Health Professional(s) involved with the Child/Young Person | | | |
| Name | | Role | Contact Details: (Email / telephone) |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Contact(s) completing this report | | | | |
| Name(s) in caps: |  | | | |
| Designation/Job title: |  | | | |
| Telephone No: |  | Email: |  | |
| Work Address: |  | | | |
| Signature: |  | | | Date: |

|  |
| --- |
| Please return completed Appendix together with all supporting reports to:  SendAssessmentTeam@kent.gov.uk and copy in kmicb.kmsendhco@nhs.net |