

Appendix 4

Advice for Statutory Needs Assessment

from Health

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

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| 1. Child/Young Person’s personal details | | | | | | |
| Full Name: |  | | | | | |
| DOB: |  | | Current Year Group: | | |  |
| Gender at birth: | Male/Female | | | | | |
| Which gender does the child/young person identify with if different from above? | Male/Female/  gender neutral | | | | Is the child/young person gender transitioning?  Yes/No | |
| Pupil Premium: | Yes/No | CiC: | | | | Yes/No |
| EAL: | Yes/No | Is a translator required: | | | | Yes/No |
| NHS Number: |  | | | | | |
| Address: |  | | | | | |
| Tel No: |  | Email: | |  | | |
| Parent/carer name:  *(lead parent for contact)* |  | Address:  *(if different from above)*  Tel No:  *(if different from above)* | | | | |
| Details of any parental requirements to support engagement or communication: | e.g. accessibility, intervener, interpreter | | | | | |
| Indicate if information sharing restrictions are in place and if yes, please state what these are: | | | | | | Yes/No |
| Are any of the parents/carers serving members of the armed forces? | | | | | | Yes/No |

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| 1. All known Health/Medical Conditions/Diagnosis and the impact on the Child/Young Person |
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| 1. Details of Health Care Involvement | |
| Date of referral: | Reason for referral: |
| Health care needs of the Child/Young Person: | |
| Health care Interventions (including equipment/adaptations in the home): | |
| Long term plan and actions, with dates where relevant e.g. move to adult services: | |

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| 1. See Appendix 2 for suggested educational outcomes   Please record your suggested recommendations for specialist service outcomes, strategies and interventions to meet any or all of these. |

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| Communication and Interaction (C&I) – *e.g. ASD, articulation, fluency, willingness to communicate, vocabulary, understanding and language structure. Additional language/s spoken. Social skills and interaction – EY, school, home, within the community.* | | |
| Outcome: | | |
| Intervention Specify what direct/Indirect support from Specialist is needed | Frequency/duration  Specify when and for how long. Indicate if a reduction is needed during the year | Who to deliver Specify intention to link to other practitioner support i.e. integrated support or class teacher/joint assessment |
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| Cognition and learning (C&L) – *e.g. Dyslexia, approaches and attitudes to learning, reasoning, organisational skills, problem solving skills and independent learning.* | | |
| Outcome: | | |
| Intervention Specify what direct/Indirect support from Specialist is needed | Frequency/duration  Specify when and for how long. Indicate if a reduction is needed during the year | Who to deliver Specify intention to link to other practitioner support i.e. integrated support or class teacher/joint assessment |
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| Social, Emotional and Mental Health needs (SEMH) – *e.g. ADHD, ADD, self-image, confidence, anxiety, motivational factors, engagement with learning, pre-school/classroom/playground behaviour, behaviours outside setting (reported or observed).* | | |
| Outcome | | |
| Intervention Specify what direct/Indirect support from Specialist is needed | Frequency/duration  Specify when and for how long. Indicate if a reduction is needed during the year | Who to deliver Specify intention to link to other practitioner support i.e. integrated support or class teacher/joint assessment |
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| Physical and/or Sensory difficulties – *e.g. motor skills, coordination, hearing or visual difficulties, daily living skills and self-help.* | | |
| Outcome | | |
| Intervention Specify what direct/Indirect support from Specialist is needed | Frequency/duration  Specify when and for how long. Indicate if a reduction is needed during the year | Who to deliver Specify intention to link to other practitioner support i.e. integrated support or class teacher/joint assessment |
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| 4a. If there are other suggested Health Outcomes that impact on the CYP education, please record your recommendations here | | | |
| Suggested Health Outcome: | | What Area of Need does this Outcome related to? | |
| Cognition & Learning (C&L)  Communication & Interaction (C&I)  Social, Emotional & Mental Health (SEMH)  Sensory & Physical (S&P) | ☐ ☐ ☐ ☐ |
| Intervention Specify what direct/Indirect support from Specialist is needed | Frequency/duration  Specify when and for how long. Indicate if a reduction is needed during the year | Who to deliver?  Specify intention to link to other practitioner support i.e. integrated support or class teacher/joint assessment | |
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| Suggested Health Outcome: | | What Area of Need does this Outcome related to? | |
| Cognition & Learning (C&L)  Communication & Interaction (C&I)  Social, Emotional & Mental Health (SEMH)  Sensory & Physical (S&P) | ☐ ☐ ☐ ☐ |
| Intervention Specify what direct/Indirect support from Specialist is needed | Frequency/duration  Specify when and for how long. Indicate if a reduction is needed during the year | Who to deliver?  Specify intention to link to other practitioner support i.e. integrated support or class teacher/joint assessment | |
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| 1. All provision to meet outcomes for which health will make funding available (to be listed in Section G) |
| Provide details of any direct payments that will be met from the health budget. |

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| 6.Other information  *Please provide any additional relevant evidence or advice* | | |
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| 7.Current Health Professionals involved with the Child/Young Person | | | |
| Name | | Role | Contact Details: (Email, telephone or address) |
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| 8.Contact(s) completing this report | | | | | |
| Name(s) in caps: | |  | | | |
| Designation/Job title: | |  | | | |
| Telephone No: |  | | Email: | |  |
| Work Address including postcode: | |  | | | |
| Relevant Qualification: | |  | | | |
| Date professional involvement began: | |  | | | |
| Level of involvement: | |  | | | |
| Signature: |  | | | Date: | |

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| Please return completed Appendix together with all  supporting reports to: | |
| ****East Kent**** | Brook House, Reeves Way, Whitstable, Kent, CT5 3SS Tel: 03000 42 11 60  Email: [SENEast@kent.gov.uk](mailto:SENEast@kent.gov.uk) |
| North Kent | Joynes House, New Road, Gravesend, Kent, DA11 0AT Tel: 03000 41 93 45  Email: [SENNorth@kent.gov.uk](mailto:SENNorth@kent.gov.uk) |
| ****South Kent**** | Kroner House, Eurogate Business Park, Ashford, Kent,  TN24 8XU Tel: 03000 42 08 89  Email: [SENSouth@kent.gov.uk](mailto:SENSouth@kent.gov.uk) |
| ****West Kent**** | Worrall House, 30 Kings Hill Avenue, West Malling, Kent,  ME19 4AE Tel: 03000 42 09 97  Email: [SENWest@kent.gov.uk](mailto:SENWest@kent.gov.uk) |