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| **Please complete fully or this may delay the application process. Return Contact No: 020 3252 2020** | | | | |
| **Referral Date:** |  | **Date Received (office):** |  | |
| **Student Full Name:** |  | **Date of Birth:** |  | |
| **UPN:** |  | **Year:** |  | |
| **ULN:** |  | **Gender:** |  | |
| **Address:** |  | **Ethnicity:** |  | |
| **Tel:** |  | |
| **Parent/Carer:** |  | **Tel 2:** |  | |
| **Emergency Contact Person:** |  | **Tel 3:** |  | |
| **School with full address:**  **Postcode:**  **Main School Tel:** |  | **School Contacts** | | |
| **Name** | **Role / Title** | **Tel Ext.** |
| P |  |  |
|  |  |  |
| **School Nurse:**  **Nurse phone no. (if avail.)** |  | **e-mail** | | |
| **Current Attendance:** |  | **Last Day Attended:** |  | |
| **Other Agencies Involved:** |  | **Case / Key Worker(s):** |  | |
| **Is a Looked After Child:** | **Yes No** | **Has Child Protection Issue:** | **Yes No** | |
| **Has an SEN Statement:** | **Yes No** | **Child in Need:** | **Yes No** | |
| **Entitled to Free School Meals:** | **Yes No** | **Has medical needs:**  **(If ‘Yes’ please ensure** | **Yes No**  **section B is completed)** | |
|  |  | **Language spoken at home:**  **Please name language:** | **English Ot** | |

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| **Why are you applying for a place with Springboard?** |
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| **If the young person is not currently attending, please outline the reasons why. Please list medical conditions that may affect the young person’s learning, participation and achievement in School (please use section B to provide us with the full medical picture):** |
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**What schools or alternative provision, if any, have been tried?**

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**What strategies have been explored around maintaining this student in school?**

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**National Curriculum Levels KS2 / KS3 / KS4**

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| **English:** |  |
| **Maths:** |  |
| **Science:** |  |

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| **For Key stage 4 pupils, please give details of any examinations likely to be taken:** | | | |
| **SUBJECT** | **EXAM BOARD** | **DATE OF EXAM** | **PREDICTED GRADE** |
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| **If involved, name of Educational Psychologi** |

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| **Parent Agreement to share Medical Information** |
| **I give my permission for health professionals working with my son/daughter to share medical information with educational professionals by completing part B of this form.** |
| **Signed: ……………………………………………………………………………….. Date: ………………………………….** |

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| **Referral made by:** Otis Griffiths |
| **Name: Position: Date**  **Email address: Phone number(s)** |
| **Agency: Signed: Date:** |
|  |

**Referral Checklist:**

**Are any of the following an issue for this young person (past or present)?** This is very helpful to us as a quick check. Please complete even if answered elsewhere in the Application form.

**Yes No Unknown**

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| **Alcohol** |  |  |  |  |  |
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| **Learning Disability** |  |  |  |  |  |
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| **Drugs** |  |  |  |  |  |
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| **Autistic Spectrum Disorder** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Behavioural difficulties** |  |  |  |  |  |
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| **Attention Deficit Disorder** |  |  |  |  |  |
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| **Depression/emotional disorder** |  |  |  |  |  |
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| **Physical Disability** |  |  |  |  |  |
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| **Deliberate Self-Harm** |  |  |  |  |  |
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| **Youth Offending** |  |  |  |  |  |
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| **Psychosis** |  |  |  |  |  |
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| **Other: (please state)** |  |  |  |  |  |
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| **Suicide Attempts** |  |  |  |  |  |
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| **History of mental health difficulties:** |  |  |  |  |  |

**Yes No Unknown**

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| **For Child** |  |  |  |  |  |
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| **For Parent** |  |  |  |  |  |

**Medical Information (Part B)**

**Please note that, in order for Springboard to offer, or continue to offer, a service, there must be written evidence of ongoing medical intervention from a Consultant Medical Practitioner.  The student needs to have had an injury, diagnosed illness or a diagnosis of an acute mental health episode with the pupil receiving ongoing intervention from a CAMHS Professional.**

**Please ensure that Part B is fully completed otherwise this will result in a delay to the referral procedure.**

**(To be returned to the school on completion.)**

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| **Name of Student**:  **DOB:** |
| **Name of school:** |
| **School Address:** |
| **Contact:** |
| **Medical Condition :** |
| **Date pupil was first seen: Was referred to CAMHS in September 2019** |
| **Brief history of medical issues:**  . |
| **Current involvement and treatment:** |

**Future plans for medical intervention / by whom and with approximate timescales :**

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**Is the student on any medication? Please give details:**

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**Are there any issues around the safety of the student, which ought to be known to those working with him/her?**

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**Please describe the issues that make it difficult for this student to attend full-time in a mainstream school:**

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| **Likely period of absence from school:** weeks / months (please delete as appropriate.) |

**Declaration:**

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| **It is my professional opinion that the student,**  **Has had an injury/operation which currently prevents them from attending school? Yes No**  **Has a diagnosed illness which prevents them from attending school? Yes No**  **Is experiencing a diagnosed acute mental health episode that prevents them from attending school, (these students should be receiving on-going intervention from a CAMHS professional and the CAMHS Manager should counter sign the referral).**  **Yes No**  **Is experiencing mental health problems but is able to attend school either part time or full time with additional support.**  **Yes No** |
| **Are there Additional Medical Needs not mentioned above? Yes No**  **If ‘Yes’ Please specify:** |

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| **Referral made by: (Consultant / School / CAMHS / Other)** |
| **Name: Position: Date** |
| **School: Signed: Date:** |