

**Notes for completing this form:**

* Please ensure you comply with Data Protection & Security guidelines by returning the completed form securely. The preferred method is via AnyComms using the ‘Additional Needs’ tab in the drop down list and marking FAO SIS
* **This form will not be accepted if not completed in full.**
* If you have any questions about a referral, please do not hesitate to contact the relevant Head of Centre using the details on the last page.

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| **SEMH Inclusion Service Referral Form** |
| Name of School: |  |
| Referrers Contact Name: |  |
| Referrers Position:  |  |
| Contact Telephone Number:  |  | Contact Email: |  |
|  |
| **Child’s Details** |
| Name: | Date of Birth: | Gender: |
|  |  |
| UPN:  | Academic Year: | Attendance:  | Date of Admission: |
|  |  |  |  |
| **Please indicate whether the pupil falls into the following categories*:*** |
| GRT: |  | EAL |  | LAC: |  | PP: |  | FSM |  |
| Previous School/s with Dates: |
|  |
| **For Office use only**

|  |  |
| --- | --- |
| SIS staff allocated: | Date: |

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| **Parent/Carer Contact:**  |
| Parent Carer Name/s: | Relationship to Child: | Address: | Telephone No: |
|  |  |  |  |
|  |  |  |  |
| Other Contact Details: |  |
| Other Children in household if known:  |  |
|  |
| **Reason/s for Referral**  |
| Details including any barriers for learning e.g. home support, sensory needs, academic difficulties: |
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|  |
| School Interventions Tried:  |
|  |
| Previous Referral to the SEMH Inclusion Service? | Yes/No | Date |
|  |  |  |
|  |
| **School Data** |
| **Academic Achievement/levels:**  |
| Reading: | Writing: | Maths: |
|  |  |  |
| **Special Educational Needs:**  |
| SEN Support/Disability: | Top Up Funding: | EHCP: | EHCP initiated: |
|  |  |  |  |
| **Previous Fixed Term Exclusions:**  |
| Reason/Type:  | Date: |
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| **Plans and Other Agencies Involved:** |
| PSP: | Date: | EHA: | Date: | PEP: | Date: | EP: | Date: | Social care: | Date: |
| Y/N |  | Y/N |  | Y/N |  | Y/N |  | Y/N |  |
| CAMHS: | Date: | SALT: | Date: | EAL: | Date: | FSW (from EHA) | Date: | SEMH project | Date: |
| Y/N |  | Y/N |  | Y/N |  | Y/N |  | Y/N |  |
|  |
| **Pupil Information** |
| **Pupils Strengths/Interests:**  |
|  |
|  |
| **Outcomes** |
| **What do you hope the outcome of this referral will be?**  |
|  |
|  |
| **Parental consent & data processing** |
| School has discussed this referral with me, and I consent to the involvement of the SEMH Inclusion Service.*Please tick* 🖵I have read the Privacy Notice provided and give permission for the data in this form to be processed and shared with my child’s school and Herefordshire Council’s Education Services. I understand that I can withdraw my consent for data processing at any time. *Please tick* 🖵Signed ……………………………………… parent/guardian date …………………………….. |
| Name of Referrer: |  | Signed: |  |
| Role: |  | Date: |  |