

# Autism/CCN Team

# Request for Involvement

## Please complete electronically in Word

|  |  |  |  |
| --- | --- | --- | --- |
| First Name:Surname Name: |  | Date of Birth: |  |
| Year Group: |  | Chronological year if delayed/deferred: |  |
| Gender: |  | SEN Status: | EHCP /SEN Support |

|  |  |  |  |
| --- | --- | --- | --- |
| Formal diagnosis of autism: | Yes / No /Under assessment | Diagnosis given by: | Umbrella / other |
| Date of diagnosis: |  | Is the young person aware of their diagnosis? | Yes / No |

|  |  |  |  |
| --- | --- | --- | --- |
| Setting: |  | Phone: |  |
| Email (a specific, named email address for direct contact with the team) |  | SENCo: |  |
| Class Teacher / Form Tutor: |  | TA / Key worker / Mentor: |  |

## Please complete for all with parental responsibility

|  |  |  |  |
| --- | --- | --- | --- |
| Parents / Carers: |  | Phone: |  |
| Email: |  | Relationship: |  |

|  |  |
| --- | --- |
| Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parents / Carers: |  | Phone: |  |
| Email: |  | Relationship: |  |

|  |  |
| --- | --- |
| Address: |  |

**Please attach copies of any assessments, records or observations that will help us to assess the needs of this young person.**

## If there is insufficient information attached, we may not be able to process the request.

|  |  |  |  |
| --- | --- | --- | --- |
| Copy of diagnostic report attached: | Yes / No n/a | Copy of EHCP attached: | Yes / Non/a |

|  |  |  |  |
| --- | --- | --- | --- |
| Free School Meals? | Yes / No | Member of a services family? | Yes / No |
| Child Protection Register? | Yes / No | GRT Community? | Yes / No |

## Attendance over the last 3 terms if a cause for concern

|  |  |  |  |
| --- | --- | --- | --- |
| Term | Possible | Actual | % |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## Exclusions, if appropriate

|  |  |  |
| --- | --- | --- |
| Date | No. of days | Reason |
|  |  |  |
|  |  |  |

## Attainment and Progress

|  |
| --- |
| Please attach evidence of the most recent assessment of the young person’s progress and attainment. |

|  |  |
| --- | --- |
| List relevant evidence provided: |  |

|  |
| --- |
| Other services / agencies |

|  |  |
| --- | --- |
| Please list other relevant agencies / services and any named professionals involved: |  |

## School View

|  |  |
| --- | --- |
| Current strategies in place: detail Quality First Teaching / Graduated Response: |  |
| Young person’s strengths: |  |
| Young person’s main difficulties: |  |

## Focus for Autism / CCN Team Involvement

## (Discuss with Specialist Teacher / Practitioner if needed)

|  |
| --- |
|   |

## Parental View

|  |  |
| --- | --- |
| Your child’s strengths: |  |
| Your child’s main difficulties:e.g., friendships, coping with change, sensory difficulties |  |

## Your priorities for your child in school:

|  |
| --- |
|  |

**Parental consent**

**Parental consent must be obtained prior to Autism / CCN Team involvement.**

**It is the setting's responsibility to obtain this.**

**Please ensure that this has been done before returning this form as we are unable to accept referrals without parental consent.**

The setting to make parents aware of the following:

In order for us to provide the best possible service, we may need to undertake assessments and contact other professionals working with you and your family to share relevant information.

Any information we are given will be kept confidential and will only be shared with other people when necessary.

If you do not want us to contact or share information with a particular agency/professional, please advise the person referring your child.

The only exception to this is if there are concerns about a child’s safety when we have a duty under the Children Act (2004) to pass on our concerns to the appropriate authority.

**All with parental responsibility to confirm:**

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

|  |  |
| --- | --- |
| Print Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

|  |  |
| --- | --- |
| Print Name: |  |

* **I confirm that I will inform parents/carers of the date of the Autism / CCN Team visit.**
* **I confirm that I will forward all reports to parents/carers from the Autism / CCN Team.**
* **I confirm I have commissioned the hours necessary for the assessment.**

**Setting referrer:**

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Print Name: |  |
| Position: |  | Date: |  |

Please return this completed form in Word with all supporting documents

by email to autism@worcschildrenfirst.org.uk