

**Student Referral Form**

Please ensure referrals are sent to referrals@horizonsbexley.org.uk no later than 4:00pm Wednesday, before the following Wednesday panel convenes. Please mark for the attention of Michelle Lawrence, Head of Student Experience.

Panel meetings take place every two weeks. Please contact Michelle Lawrence, Head of Student Experience, michelle.lawrence@horizonsbexley.org.uk for future dates. A representative from the referring School/Academy is welcome to attend the Referral Panel to present their case. The panel commences at 16:00, school staff will be presenting on a first come, first seen basis.

It is essential that all referral forms are completed in full and additional information supplied as requested to ensure that the referral is not delayed due to lack of information.

Please complete each yellow box as required providing as much detail as possible.

| **Basic Details** |
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| Referrer completing form: |  |
| Date of completion: |  |
| Student name: |  |
| Parental consent has been obtained (Please indicate Y or N) : |  |
| Type of referral:*Please place an X in the correct option* | Satellite Centre Service: |  |
| Outreach Service: |  |
| Short Stay Programme (KS1/2/3): |  |
| Long Term Placement (KS4 only): |  |
| PEX Student: |  |

| **Student Details** |
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| Forename: |  |
| Surname: |  |
| UPN: |  |
| Gender: |  |
| Date of Birth: |  |
| Year Group: |  |
| Ethnicity: |  |
| Language Spoken at Home: |  |
| ID Seen - Passport (Provide Date): |  |
| ID Seen - Birth Cert (Provide Date): |  |
| Free School Meals (Y/N): |  |
| Pupil Premium (Y/N): |  |
| Looked After Child (Y/N): |  |
| Previously LAC (Y/N): |  |
| LAC Home Authority: |  |
| LACE Officer: |  |

| **Home School/Academy Details** |
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| School/Academy Name: |  |
| School/Academy Address: |  |
| Contact Name: |  |
| Contact Telephone Number: |  |
| Contact Email Address: |  |
|  |  |

| **Family Details** |
| --- |
| Mother | Title: |  |
| Name: |  |
| Parental Responsibility: |  |
| Address: |  |
| Telephone Number: |  |
| Email Address: |  |
| Father | Title: |  |
| Name: |  |
| Parental Responsibility: |  |
| Address: |  |
| Telephone Number: |  |
| Email Address: |  |
| Siblings | Name | School/Academy Attended |
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| **Current Agency Involvement** (Please place an X next to each agency involved) |
| Family Wellbeing: |  | Community Safety: |  |
| Child in Need: |  | St Giles Trust: |  |
| Child Protection: |  | PREVENT/CHANNEL: |  |
| Charlton Athletic: |  | Targeted Youth: |  |
| Serious Violence Panel: |  | Moorings: |  |
| CAMHS: |  | BASS/Porchlight: |  |
| Youth Offending Team: |  | Crest: |  |
| Name and contact details of allocated workers (Including Social Worker) |  |
| Give an accurate overview of reasons for agency involvement: |  |

| **Special Educational Needs** |
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| Do you consider this student suitable to mainstream education? (Y/N): |  |
| Is a statutory assessment being initiated? (Y/N): |  |
|  If “Y” then please provide details by who: |  |
|  If “Y” then please provide details of what stage it is: |  |
| Has a statutory assessment been carried out? (Y/N): |  |
|  If “Y” then please provide details by who: |  |
|  If “Y” then please provide date of assessment: |  |
| Has the student been seen by an Educational Psychologist? (Y/N): |  |
|  If “Y” then please provide date seen: |  |
|  If “Y” then please provide date of report: |  |
| **PLEASE ATTACH COPIES OF ANY REPORTS WITH THIS REFERRAL** |

| **Areas of Need** |
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| *Please place an X in the appropriate option(s) for each Area of Need* | Observed | Diagnosed | Medicated | Under Assessment | Referred | None |
| Autistic Spectrum Disorder: |  |  |  |  |  |  |
| Speech and Language: |  |  |  |  |  |  |
| General Learning Difficulty: |  |  |  |  |  |  |
| Specific Learning Difficulty: |  |  |  |  |  |  |
| Attention Deficit Hyperactivity Disorder: |  |  |  |  |  |  |
| Social, Emotional and Mental Health: |  |  |  |  |  |  |
| Emotional and Social: |  |  |  |  |  |  |
| Mental Health: |  |  |  |  |  |  |
| Hearing Impairment: |  |  |  |  |  |  |
| Visual Impairment: |  |  |  |  |  |  |
| Physical/Medical: |  |  |  |  |  |  |
| Wellbeing: |  |  |  |  |  |  |
| Provide further context of areas of need: |  |
| Medication: |  |

| **Attendance and Fixed Term Exclusions** (please attach attendance certificate) |
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| Current year attendance (%): |  |
| Previous year attendance (%): |  |
| Number of Fixed Term Exclusions this year: |  |

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| **Student Attainment** |
| *Please place an X to indicate whether the student is below, on track or above age-related expectations.* | Below | On Track | Above |
| Phonics Screening (KS1): |  |  |  |
| Spelling Age: |  |  |  |
| Reading Age: |  |  |  |
| CAT Scores: |  |  |  |
| English: |  |  |  |
| Maths: |  |  |  |
| Science: |  |  |  |
| Other information: |  |

| **Additional Information** |
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| Has the student been involved in a serious one-off incident that would otherwise result in a permanent exclusion? |  |
| Please give details: |  |
| IS there specific behaviour requiring intervention or support that has been evidenced by the school/academy and addressed through school-based interventions but without significant impact? |  |
| Please outline interventions and any impact to date to support the referral: |  |
| Has the Outreach Team been involved? |  |
| Please give details and any outcomes to support the referral: |  |
| Has a managed move between mainstream schools been tried but not successful? |  |
| Please give details and dates: |  |
| Would the student benefit from a period out of school to break the cycle of behaviours? |  |
| Please give details: |  |

| **Parent/Carer Views** |
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| What would they like to happen? What do they hope their child will gain from accessing our services? |
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