|  |
| --- |
| **SPECIALIST SUPPORT TEAM FOR PUPILS WITH MEDICAL AND/OR PHYSICAL NEEDS (MPN)****Referral Form** |

**SECTION A**

The MPN Team is part of Wirral Council’s Children’s Services. The Team works with schools to support children with medical and/or physical needs in mainstream settings. In liaison with schools, the MPN Team aims to: promote inclusive practice; identify and remove barriers to participation and learning; advance equality of opportunity.

In supporting schools to meet these aims, and in response to a referral, team members may carry out a number of functions including:

* Attendance at meetings both in school and other related contexts.
* Individual health care planning with parents, school, and relevant professionals.
* Liaison with relevant professionals.
* Observation of a pupil in the school environment.
* Collecting a pupil’s views.
* Learning assessment.

***In delivering these functions, personal data will be collected about individual pupils, and may be exchanged and shared within the context of individual health care planning and requests for Individual Pupil Funding Agreements (Medical/Physical). Personal data will be processed and used in line with Wirral Council’s Data Protection Policy. For full details of the policy and the Council’s Principal Privacy Notice please visit:***

**IN ORDER FOR A REFERRAL TO BE PROCESSED QUICKLY**

**IT IS ESSENTIAL THAT ALL PARTS OF THIS FORM ARE COMPLETED FULLY**

|  |
| --- |
| **SECTION B: REFERRER DETAILS** |
| **Referral Source:** | **School/Setting** [ ]  **Health 0-19** [ ]  **Parent** [ ]  **Other** [ ]  |
| **Name:** |  | **Job Role:** |  |
| **Email:**  |  | **Landline****Mobile** |  |
| **School/Setting (if applicable)** |  | **Date of Referral:** | *click or tap to enter a date* |

|  |
| --- |
| **SECTION C: CHILD’S DETAILS** |
| **Forename(s):** |  | **Gender:** | **Male**  [ ]  **Female** [ ]  |
| **Surname:** |  | **Date of Birth:** | *click or tap to enter a date* |
| **Current****School/Setting:** |  | **Year Group:** | *click or tap to select year group* |
| **School/Setting****Sessions:** | *e.g. School: Mon-Fri, 10 sessions*  *Setting: Mon & Thurs, 9.00-12.00* | **Attendance Data:** |  |
| **Social Care Status:** | **TAF** [ ] [x]  **CIN** [ ]  **CP** [ ]  **CLA** [ ]  **PCLA** [ ]  |

[***https://www.wirral.gov.uk/about-council/freedom-information-and-data-protection/data-protection-policy***](https://www.wirral.gov.uk/about-council/freedom-information-and-data-protection/data-protection-policy)

|  |
| --- |
| **SECTION D: REASON FOR REFERRAL** |
| Help and advice with transitionFor preschool transition please complete Section D1 below |[ ]
| Help and advice with individual health care planning  |[ ]
| Help and advice with curriculum access and learning assessment |[ ]
| Individual Pupil Funding Agreement (IPFA) Request |[ ]
| Other |[ ]
| Please specify: |  |

|  |
| --- |
| **SECTION D1: CHILD IN TRANSITION** |
| **Only complete this section if the referral is being made as part of the transition arrangements** **for a preschool child starting school.****If the referral is not part of transition arrangements, go straight to Section E.** |
| **Is the child known to the EY SEND Team** | **NO**  [ ]  **YES** [ ]  | **Name of EY SEND Officer:** |  |
| **Sessions taken at current setting:** | *e.g. Monday & Thursday, 9.00-12.00* |
| **Name of Key Worker:** |  | **Receiving Setting:** |  |
| **Specialist equipment used in setting:** |  | **Occupational Therapist:** |  |
| **Funding** |
| Is an EHC assessment underway? | YES [ ]   | NO [ ]   | APPLIED [ ]  |
| Additional Information: |
| Is the child in receipt of Inclusive Practice Funding?  | YES [ ]  | NO [ ]   | APPLIED [ ]  |
| Additional Information:  |
| Is the child in receipt of Disability Living Allowance?  | YES [ ]   | NO [ ]   | APPLIED [ ]  |
| Additional Information: |
| Is the child in receipt of Disability Access Fund? | YES [ ]   | NO [ ]   | APPLIED [ ]  |
| Additional Information: |

|  |
| --- |
| **SECTION E: PROFESSIONALS CURRENTLY INVOLVED WITH THE CHILD** |
|  **Service or Agency** |  | **Named Professional** |
| Occupational Therapist | YES [ ]  NO [ ]  |  |
| Physiotherapist | YES [ ]  NO [ ]  |  |
| Community PaediatricianGeneral Consultant Paediatrician | YES [ ]  NO [ ] YES [ ]  NO [ ]  |  |
| Community Dietician | YES [ ]  NO [ ]  |  |
| Continuing Care Team | YES [ ]  NO [ ]  |  |
| Specialist Nurses: |  |
| Cardiac Liaison | YES [ ]  NO [ ]  |  |
| Continence  | YES [ ]  NO [ ]  |  |
| Cystic Fibrosis | YES [ ]  NO [ ]  |  |
| Diabetes | YES [ ]  NO [ ]  |  |
| Epilepsy | YES [ ]  NO [ ]  |  |
| Respiratory (Asthma & Allergy) | YES [ ]  NO [ ]  |  |
| Oxygen | YES [ ]  NO [ ]  |  |
| Oncology Outreach (Macmillan) | YES [ ]  NO [ ]  |  |
| CAMHSHospital-based TherapyFamily Support Team, Claire House | YES [ ]  NO [ ] YES [ ]  NO [ ] YES [ ]  NO [ ]  |  |
| Other - please specify: |  |
| SENAAT | YES [ ]  NO [ ]  |  |
| Educational Psychology | YES [ ]  NO [ ]  |  |
| Other – please specify: |  |
| Social Care | YES [ ]  NO [ ]  |  |
| Home/Cont. Education Service | YES [ ]  NO [ ]  |  |

|  |
| --- |
| **SECTION F: SUMMARY OF CHILD’S NEEDS** |
| **If the child has an Individual Health Care Plan, please attach it to this referral.** |
| Diagnosis/Medical Condition: |
| Please provide details of the child’s needs. Where appropriate, include information about the following: walking, toileting, feeding, medication, therapies, attendance, emotional wellbeing, and learning. |

|  |
| --- |
| **SECTION F: PARENT/CARER DETAILS** |
| **Name of Person with** **Parental Responsibility:** | *click or tap to select title* |  |
| **Relationship with Child:** |  |
| **Phone Number(s):** |  |
| **Email:** |  |
| **Address:** |  |

|  |
| --- |
| **SECTION F: PARENT/CARER DETAILS** |
| **Name of Person with** **Parental Responsibility:** | *click or tap to select title* |  |
| **Relationship with Child:** |  |
| **Phone Number(s):** |  |
| **Email:** |  |
| **Address:****(if different from above)** |  |

|  |
| --- |
| **SECTION F1: PARENT/CARER CONSENT** |
| **Parental consent must be obtained for this referral to be actioned.****The referral will not be considered without parent/carer penned signature below.** |
| * I have read and I understand the information detailed in Section A of this referral form.
* I have read Wirral Council’s Data Protection Policy and Principal Privacy Notice. I agree to my child’s data being processed and shared by Wirral Council in line with the policy.
* I give consent for this referral.
 |
| Name (Print): | Signature: | Date: |