OUTREACH REFERRAL FORM

Please complete this form if you would like to refer a pupil to Southampton Hospital School’s Outreach provision.

Southampton Hospital School can only provide tuition for pupils who are unable to attend their usual school due to evidenced medical needs. Schools should note that this service is not a long-term provision, but has been established to support reintegrating pupils whose education has been disrupted by their medical needs. Spaces are limited, however all completed referrals will be considered, providing:

* The child is enrolled at a Southampton school in years R to 11.
* There is medical evidenced submitted with the referral outlining the medical need(s).
* The medical need(s) are evidenced to be the primary reason for non-attendance at school.
* Parental support for the Outreach referral has already been sought and agreed.

Admissions are managed by a panel of Southampton Hospital School staff led by the Headteacher. The panel meets once a week to review and consider all referrals. We therefore aim to respond to all referrals within 5 working days of receipt.

Once a space has been identified and a referral has been agreed, SHS will request a statutory data transfer (through the S2S website) in order to dual-roll the pupil. The outreach team will also make contact with yourselves to arrange an initial interview with the family & finalise the reintegration timetable for tuition.

Throughout the admission, SHS will continue to liaise with parents and yourselves in order to assess an appropriate level and frequency of tuition (up to a weekly maximum of five sessions per pupil). Each admission is periodically reviewed and extensions beyond six weeks are only agreed following review of the medical criteria and the progress towards the agreed reintegration targets.

The Outreach service is charged by invoice once the provision ends, please see the charging document for more information.

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Completed referrals should be sent by AnyComms+ to *Admin* at *Southampton Hospital School*, or via post to:

*Outreach Panel*

*Southampton Hospital School*

*119 Tremona Road*

*Southampton*

*SO16 6HU*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| INITIAL INFORMATION |  | | | A |
| PUPIL FULL NAME: | | | PUPIL DOB: | |
| PUPIL HOME ADDRESS: | | | PUPIL SCHOOL YEAR: | |
| PARENT NAME: | | PARENT CONTACT NUMBER: | | |
| REFERRING SCHOOL: | | | DATE OF REFERRAL: | |
| NAMED SCHOOL CONTACT: | | NAMED CONTACT DIRECT NUMBER: | | |
| NAMED SCHOOL CONTACT ROLE: | | NAMED CONTACT EMAIL ADDRESS: | | |
| PLEASE CONFIRM YOU HAVE COMPLETED AN INDIVIDUAL HEALTHCARE PLAN FOR THIS CHILD:  ATTACHED BELOW / NOT COMPLETED | | | DATE STARTED AT SCHOOL: | |
|  | | | | |
| ATTENDANCE HISTORY |  | | | B |
| PUPIL’S ATTENDANCE % FOR CURRENT YEAR: | | DATE PUPIL WAS LAST PRESENT AT SCHOOL: | | |
| PUPIL’S ATTENDANCE % LAST ACADEMIC YEAR: | | DATE PUPIL’S ATTENDANCE BECAME CONCERN: | | |
| CURRENT REGISTER CODE USED FOR PUPIL’S ABSENCE: | | NUMBER OF DAYS ABSENT THIS YEAR DUE TO MEDICAL NEEDS: | | |
| DETAILS OF AGREED PART-TIME TIMETABLE (IF APPLICABLE):  REDUCED TIMETABLE ARRANGEMENTS:  DATE STARTED:  DATE OF NEXT REVIEW: | | | | |

**OUTREACH REFERRAL FORM**

ALL SECTIONS MUST BE COMPLETED

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| MEDICAL INFORMATION |  | | | | | C |
| PRIMARY MEDICAL NEED: | | MEDICAL EVIDENCE ATTACHED IN SUPPORT: | | | | |
| ADDITIONAL MEDICAL NEED(S): | | MEDICAL EVIDENCE ATTACHED IN SUPPORT: | | | | |
| PLEASE OUTLINE WHY THE ABOVE MEDICAL NEED(S) PREVENT SCHOOL ATTENDANCE: | | | | | | |
| PLEASE OUTLINE THE INTERVENTIONS AND SUPPORT THAT HAS ALREADY BEEN PUT IN PLACE: | | | | | | |
| PLEASE LIST THE OTHER SERVICES & CONTACTS DETAILS OF THOSE INVOLVED IN SUPPORTING THIS CHILD (AND FAMILY): | | | | | | |
|  |  | | | | | |
| EDUCATIONAL NOTES |  | | | | | D |
| WHAT ARE THE PUPIL’S CURRENT LEVELS OF ATTAINMENT: | | | | | | |
| IS PUPIL ON S.E.N. REGISTER (INCLUDE APPROPRIATE CODE): | | DOES THE PUPIL HAVE AN EHCP (INCLUDE REVIEW DATE):  ATTACHED BELOW / NOT APPLICABLE | | | | |
| IS THE PUPIL A LOOKED AFTER CHILD: | | DOES THE PUPIL ATTRACT ANY ADDITIONAL FUNDING: | | | | |
| PLEASE OUTLINE WHAT YOU HOPE TO ACHIEVE THROUGH THIS REFERRAL TO THE OUTREACH SERVICE: | | | | | | |
| DECLARATIONS |  | | | | | E |
| MEMBER OF STAFF COMPLETING THIS REFERRAL  I HAVE ENSURED THE CHILD’S PARENTS/CARERS ARE AWARE OF THIS REFERRAL AND ITS CONTENTS AND THAT THEY HAVE GIVEN THEIR FULL SUPPORT. I HAVE ALSO ENSURED ALL RELEVANT DOCUMENTS ARE ATTACHED AS DETAILED IN SECTIONS C & D.  **SIGNED:………………………………………………………………………………………….. DATED:…………………………………………….** | | | | | | |
| REFERRING HEADTEACHER  I SUPPORT THIS REFERRAL OF THE ABOVE NAMED PUPIL TO SOUTHAMPTON HOSPITAL SCHOOL AS THEIR MEDICAL NEEDS ARE PRIMARILY RESPONSIBLE FOR PREVENTING THEIR ATTENDANCE AT THIS SCHOOL. I HAVE READ AND UNDERSTOOD THE RELEVANT DOCUMENTS AND ACCEPT THERE WILL BE A CHARGE FOR THIS SERVICE.  **SIGNED:………………………………………………………………………………………….. DATED:…………………………………………….** | | | | | | |
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| **DO NOT WRITE BELOW THIS LINE**  --------------------------------------------------------------------------------------------------------------------------------------------- | | | | | | |
| SHS – OFFICE USE ONLY |  | | | | RECEIPT | |
| DATE REFERRAL RECEIVED: | | RECEIVED BY: | | | | |
| HAVE ALL SECTIONS BEEN SIGNED & COMPLETED:  YES | NO | | ARE ALL RELEVANT DOCUMENTS ATTACHED:  YES | NO | | | | |
| *IF “NO” TO EITHER OF ABOVE REJECT REFFERAL AND RETURN STATING REASON. OTHERWISE, FORWARD TO PANEL.* | | | | | | |
|  | | | | | | |
| SHS – PANEL USE ONLY |  | | | | PANEL | |
| DATE REVIEWED BY PANEL: | | REVIEWED BY: | | | | |
| PANEL DECISION: | | | | | | |
|  | | | | | | |
| SHS – OFFICE USE ONLY |  | | | | ENROLLED | |
| DATE PLACE AVAILABLE FROM: | | TUTOR: | | | | |
| INITIAL INTERVIEW DATE: | | SCHOOL CONTACT ATTENDING: | | | | |
| START DATE: | | 1ST Review | 2nd Review | 3rd Review | | 4th Review |
| END DATE: | |