**Health advice template .**

**PROFESSIONAL INFORMATION/ADVICE TO SUPPORT THE DEVELOPMENT OF AN EDUCATION, HEALTH CARE PLAN FOR A CHILD/YOUNG PERSON**

This information is sought in accordance with the Children and Families Act 2014. The Local Authority is seeking advice as part of statutory Education, Health and Care needs assessment. Advice must be returned within **6 weeks of the request being made. This advice is therefore required by DATE HERE.**

Please complete from the perspective of your own service/area of expertise. **Not all sections need to be completed if they are not applicable (delete sections as required).** Please ensure information is clear, concise and accessible. Please refer to service specific guidelines to support completion of this advice.

**Part 1: Child/Young Person’s Details – if prepopulated, please check details and amend if needed**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Forename:** |  | **Surname:** | |  |
| **Home address:** |  | | | |
| **Home borough:** |  | **Gender:** | |  |
| **Date of Birth:** |  | **Age:** | |  |
| **Ethnicity:** |  | **Religion:** | |  |
| **Languages spoken at home:** |  | **Is interpretation required?** | |  |
| **Family information** | | | | |
| **Name of Parent/Carer:** |  | | | |
| **Address:** |  | | | |
| **Telephone:** |  | | | |
| **Email address:** |  | | | |
| **Educational Setting (leave blank if none)** | | | | |
| **Name of Educational Setting:** |  | | | |
| **Setting Address:** |  | | | |
| **Year Group at time of assessment:** |  | | **Unique Pupil Number (if known):** |  |
|  | | | | |
| **Name of GP:** |  | | **NHS Number:** |  |
| **Name and Address of GP Surgery:** |  | | **ICB:** |  |

The long-term aspirations for learning, good health, relationships and independence to prepare for adulthood.

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| --- |
| **Aspirations of the child/ young person** |
| **Aspirations of the family** |

|  |  |
| --- | --- |
| **Part 2 : Name of Service Providing Information/Advice** | **Enter name of Service here:** |

**Advice givers details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Profession:** |  |
| **Address of workplace:** |  | **Telephone no.** |  |
|  |  | **Email address:** |  |
| **Provide a brief summary of the child / young person’s contact with the service** |  | | |

**Reason advice is being provided:**

|  |
| --- |
| **EHC Needs Assessment  Annual review  Transition** |

**Part 3: SUMMARY OF EDUCATION HEALTH AND CARE NEEDS**

Please include reference to recent assessments completed in Appendix A.

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| --- |
| **About the Child/Young Person** |
|  |

|  |
| --- |
| **COGNITION AND LEARNING** |
| **Strengths and how these are supporting learning** |
|  |
| **Needs and impact on learning** |
|  |
| **Outcomes** |
|  |
| **Provision** |
|  |

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| --- |
| **COMMUNICATION AND INTERACTION** |
| **Strengths** **and how these are supporting learning** |
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| **Needs and impact on learning** |
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| **Outcomes** |
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| **Provision** |
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| **SOCIAL, EMOTIONAL AND MENTAL HEALTH** |
| **Strengths** **and how these are supporting learning** |
|  |
| **Needs and impact on learning** |
|  |
| **Outcomes** |
|  |
| **Provision** |
|  |
| **SENSORY AND PHYSICAL** |
| **Strengths and how these are supporting learning** |
|  |
| **Needs and impact on learning** |
|  |
| **Outcomes** |
|  |
| **Provision** |
|  |
| **SELF-CARE AND INDEPENDENCE (PREPARING FOR ADULTHOOD)** |
| **Strengths** **and how these are supporting learning** |
|  |
| **Needs and impact on learning** |
|  |
| **Outcomes** |
|  |
| **Provision** |
| Home / Community  Education |
| **MEDICAL/NURSING information related to the child’s learning difficulties or disabilities/ Eating/Drinking** |
| **Needs** **and impact on learning** |
|  |
| **Outcomes** |
|  |
| **Provision** |
|  |
| **SOCIAL CARE** |
| **Needs and impact on learning** |
|  |
| **Outcomes** |
|  |
| **Provision** |
|  |
| The school should also endeavour to seek additional support to meet this child/young person’s needs. Possibilities include signposting to appropriate services, making use of suitably trained colleagues within the school setting or seeking additional resources locally to support need (i.e. Local Offer training/information). |

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| **Has this advice been discussed and agreed with child, Young Person and parent/ carer** | |
| Yes | No |

|  |  |
| --- | --- |
| **Name of Person Providing Advice:** |  |
| **Signature:** |  |
| **Date:** |  |

**ONCE COMPLETED PLEASE RETURN THIS ADVICE WITH ANY OTHER RELEVANT INFORMATION TO:**

EHCP Coordinator:

|  |  |  |  |
| --- | --- | --- | --- |
| **For office use only** | | | |
| Date Received |  | Response due by |  |
| Case Officer |  | Panel Date |  |

**Appendix A: Assessments completed and other relevant clinical evidence (delete if not relevant).**