YPRSA

**SECTION 1: Guidance**

Young Person’s Request for Education, Health and Care Needs Assessment

* Normally children / young people should only be referred for statutory assessment following a graduated approach of intervention, as advised in the SEND Code of Practice 2015 and Local Guidance; SEN Support and Education, Health and Care Plans, see [Graduated Approach to Special Educational Needs and Disabilities (SEND) | City Of Wolverhampton Council](https://www.wolverhampton.gov.uk/education-and-schools/graduated-approach-special-educational-needs-disabilities#:~:text=Graduated%20Approach%20to%20Special%20Educational%20Needs%20and%20Disabilities,that%20might%20support%20them%20in%20overcoming%20these%20barriers.)
* The form below outlines information that **must** be completed. Partially completed forms will be returned for full completion.
* Additional reports must be added to a zip file and emailed to SENSTART@wolverhampton.gov.uk as an electronic copy within the zipped file.

From January 2023

All requests for an EHC Needs Assessment MUST be made on this form and emailed to SENSTART@wolverhampton.gov.uk.

**SECTION 2: Consent**

In requesting a single assessment, I am also consenting for the Royal Wolverhampton Hospitals NHS Trust to disclose medical information either from my medical records or, if necessary, to a medical examination.

This form is only for young people 16 years of age or older. If you are under 16, please ask your parent to complete the Parent EHC Needs Assessment form

A: Consent

|  |  |  |  |
| --- | --- | --- | --- |
| A1 | Are you over 16 years of age? | Yes | No **(If so, please complete the Parent EHC Needs Assessment form)** |
| A2 | Do you consent to this request | Yes | No |

|  |  |  |
| --- | --- | --- |
| A3 | By completing this form, you are consenting for your information to be shared with other professionals involved | ¨ Tick the box to confirm that you have understood the contents of this form may be shared with other involved professionals. |

**SECTION 3: Key Information for EHC Needs Assessment**

B: Your Details

|  |  |  |
| --- | --- | --- |
| B1 | Your full name  |  |
| B2 | Your date of birth |  |
| B3 | Your Address |  |
| B4 | Your telephone number |  |
| B5 | Your email address |  |
| B6 | Your ethnicity |  |
| B7 | Your gender |  |
| B8 | Your home language and/or best way to communicate with you |  |
| B9 | Are you from a UK Armed Forces or crown servant family? | Yes/No (Please delete as appropriate) |
| B10 | Is this the first request made for the you? | YES | NO- please state the previous date of request:dd/mm/yy |
| If less than 6 months from the date of this request, this request will not be accepted |

C: Advocate/Friend/Relative/Social Worker

|  |  |  |  |
| --- | --- | --- | --- |
| C1 | Is there another person who you would like to help you with the Education Health Care Needs Assessment process? | YES  | NO  |

C Details of advocate / Friend/Relative/Social Worker

|  |  |  |
| --- | --- | --- |
| C2 | Title |  |
| C2 | Surname |  |
| C3 | Forename |  |
| C4 | Relationship to the Young Person | Mother / Father / Brother / Sister / Grandmother / Grandfather / Aunt / Uncle / Cousin / Other (please state) |
| C5 | Private Email Address |  |
| C6 | Telephone Number |  |
| C7 | Alternative Telephone Number  |  |
| C8 | Address (if different from young person) |  |
| C9 | Home Language |  |
| C10 | Is interpreter needed? |  |
| C11 | Does the parent/guardian have a known disability that we need to be aware of? |  |
| C12 | If YES please provide details so we can make reasonable adjustments for you.  |  |

D: Details General Practitioner Involved (Details MUST be completed to progress this request)

|  |  |  |
| --- | --- | --- |
| D1 | GP Surgery Name: |  |
| D2 | Registered GP’s Name: |  |
| D3 | GP Surgery Address: |  |
| D4 | GP Surgery Telephone Number: |  |
| D5 | GP Surgery E-mail |  |

E: Details of Education, Health & Social Care Professionals Involved:

This information will help the Authority to find out what steps have been taken to help you so far.

NOTE - If you have received input from a medical professional please provide copies of the medical reports. –

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| E1 Name |  E2Title Professional Role | E3 Advice area | E4 Address & Contact Number  | E5 Email address |
|  |  | Education / Health, Social Care / Voluntary Sector / Other  |  |  |
|  |  | Education / Health, Social Care / Voluntary Sector / Other  |  |  |
|  |  | Education / Health, Social Care / Voluntary Sector / Other  |  |  |
|  |  | Education / Health, Social Care / Voluntary Sector / Other  |  |  |
|  |  | Education / Health, Social Care / Voluntary Sector / Other  |  |  |
|  |  | Education / Health, Social Care / Voluntary Sector / Other  |  |  |

F: Details of Current Education Setting:

|  |  |  |
| --- | --- | --- |
| F1 | Name of your current Educational Setting: |  |
| F2 | Address of your setting, school, or provider: |  |
| F3 | Date you started at this education setting: |  |
| F4  | SENCo’s name (if known): |  |

G: Previous Education Setting Information (please add to this if you have attended multiple previous settings):

|  |  |  |
| --- | --- | --- |
| G1 | Name of your Previous Educational Setting  |  |
| G2 | Name(s) of Local Authority where your previous education setting located |  |
| G3 | Date you started at this education setting: |  |
| G4 | Date you left this education setting: |  |

H. Your educational needs

|  |  |  |
| --- | --- | --- |
| H1 | What are your concerns about your special educational needs? |  |
| H2 | If you are in an educational setting, have you been placed on the SEN support register in your educational setting? |  |

1. **Your Health Needs**

|  |  |  |
| --- | --- | --- |
| I1 | What health needs do you have? (Please include formal diagnosis and dates)*.* |  |
| I2 | Please describe how the medical conditions or health needs impact on you on a day to day basis.  |  |

J. Detail how you are supported at home and in the community

|  |  |  |
| --- | --- | --- |
| J1 | Do you take part in any activities within the community? E.g. Scouts, Cadets, swimming, football etc |  |
| J2 | Do you require any support accessing any of these activities? |  |
| J3  | What is working well for you and your family at home? |  |
| J4 | What is not working well for you and your family at home? |  |

K: Reason for the Education Health Care Needs Assessment

|  |  |  |
| --- | --- | --- |
| K1 | Why do you think you need an Education Health Care needs assessment now? |  |
| K2 | What is important to you now and for the future? |  |
| K3 | Do you have any supporting documents that you would like to share? YES/NO | YES(please upload to a zip file with your email) | NO |

L: Young Person Signature (please sign your name, typed signatures cannot be accepted)

Name:

Signed: Date:

“This form may be issued only by and for the use of Wolverhampton Authority. It may not be copied or reproduced by any other party.”

Please complete all sections of the form and email this to SENSTART@wolverhampton.gov.uk