

**Play Therapy**

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| Pupil Surname |  |
| Pupil Forename (s) |  | Sex | □ Female □ Male□ Non-Binary Gender |
|  Date of Birth |  | NC Year |  | Pupil UPN |  |
| Parent(s)/Carer(s) |  |
| Address |  |
| Telephone |  |
| If parents live separately, please provide contact details for both parents if different to the above |
| Parent(s)/Carer(s) |  |
| Address |  |
| Telephone |  |
| Who has parental responsibility? |  | Is pupil in LAC system | □ Yes □ No |
| School |  |
| School Postcode |  | School Telephone |  | Attendance in Previous Term (%) |  |
| SENCo Email |  |
| SENCo |  | Class Teacher/Form Tutor |  |
| **Are there any medical conditions**? E.g. epilepsy, cerebral palsy etc. □ Yes □ NoIf yes, please give details:  |
| **Diagnoses (please select all that apply):**□ None □ Dyslexia □ Dyscalculia □ Dyspraxia □ ASD □ ADHD □ Other (please specify): |
| **Areas of concern:** |
| **Service package required** (select one):□ Initial Assessment □ Block of therapy (as per assessment report) |
| **Please indicate which services are involved with the pupil:** e.g. Educational Psychology, OT etc.. |
| Please attach copies of the following reports *(where relevant)** Pupil’s current IEP / Provision Map
* Most recent reports from other agencies
* Most recent SAT results and Teacher Assessment Levels
* Any recent observations by Class Teacher / SENCO / Head of Year / EWS
* Any other reports which may be relevant to support the referral
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| Does the pupil wear glasses? □ Yes □ No*If yes, please ensure that they have them with them on the day of the assessment* |
| Does the pupil have reading or writing difficulties? □ Yes □No*If yes, please give details:*  |
| **Please indicate the pupil’s status regarding the SEN Code of Practice:**□ Does not have SEN □ SEN Graduated Response □ Integrated Assessment requested □ EHCP |
| **Is the pupil on the Umbrella Pathway?** □Yes □No*If yes, which professionals are involved?*  |
| *In* ***all*** *cases, parental consent must be obtained* ***prior*** *to CSSS involvement. It is the commissioning school’s responsibility to obtain this. Please ensure that this has been done before returning this form. Please see our GDPR privacy statement regarding data protection. Photographs may be used as part of the assessment and these will be stored securely in line with GDPR regulations. Reports will be shared, as required, with other appropriate specialists within the CSSS support portfolio (e.g. SALT).* |
| I confirm that parents/carers have consented to CSSS involvement □ |
| Signature of person commissioning support: | Position: |
| Name (in capitals): | Date:  |
| ***We regret that we cannot accept typed signatures. Digital signatures or scanned electronic copies are suitable.*** |
| ***Please return completed referral forms via:*** **Worcestershire County Council Children’s Services Portal** – select named individual – TERESA HAMILTON***OR******EGRESS –*** *schoolsupportservices@chadsgrove.worcs.sch.uk* |
| **Chadsgrove School Support Services**Meadow RoadCatshill, BromsgroveWorcestershire, B61 0JL**Tel:** 01527 871511 (option 2)**Email:** schoolsupportservices@chadsgrove.worcs.sch.uk**Website:** [https://www.chadsgroveschool.org.uk](https://www.chadsgroveschool.org.uk/web/school_support_services)@chadsupportteam  |