

**Medical Tuition Service**

**MEDICAL REFERRAL FORM**

**TO BE COMPLETED BY:**

* Member of Community Paediatrician Team
* Hospital Consultant
* Clinical Psychologist
* Consultant Child & Adolescent Psychiatrist
* CAMHS Practice Manager

The information you provide informs the Panel as to whether or not this is an appropriate referral. Therefore please complete ALL sections as comprehensively as possible.

I have sought parental permission to share the following information and I am aware that this information may be shared with other professionals working in the Education, Health and Social Care Directorate.

**Student School contacted: Yes □ No □** (please tick)

**Section 1**

|  |  |
| --- | --- |
| Referrer’s Name: | Position: |
| Contact Address: |
| Organisation: |
| Phone Number: | Date: |
| Email:  |

**Section 2**

|  |  |
| --- | --- |
| Name of Student: | D.O.B: |
| School: | National Curriculum Year: |
| Name of Parent/Carer:  |
| Student Home Address:  |
| Telephone Number: |

**Section 3**

Is there a safeguarding concern? Yes □ No □ (please tick one)

(If YES please give details)

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**Section 4:**

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| Medical Diagnosis: |  |
| Date the medical diagnosis was formally identified:  |  |
| By Whom:  |  |

**Please attach the care plan.**

How does the medical condition impact on the student’s ability to access education? e.g. energy levels, engagement etc.

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What on-going support or action is your organisation providing, prescribing or putting in place for this student? Please list:

*e.g. Early Help*

 *Ongoing therapeutic intervention*

 *Medication (please specify)*

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Please list all people/agencies that have been involved to date:

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Please add any other information you feel which may impact upon this student’s recovery and eventual re-integration into School:

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Next Medical Assessment due date:

It is assumed that this medical condition will continue until the end of student’s school career.

Yes □ No □ Unknown □ (please tick one)

Termly review meetings will be held. Please give a name & contact details for a termly medical update:

|  |
| --- |
| Name: |
| Contact details (phone/email): |

**If medical advice on managing this illness is given to the parents, please attach a copy to this referral.**

|  |  |
| --- | --- |
| **Completed by:** | **Position:** |
| **Signed:**  | **Date:** |

Medical Tuition Service, Torbay Council, Halswell House, 53 Totnes Road, Paignton, TQ4 5LE

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Email EOTAS@torbay.gov.uk

Please return this completed form by email to jayne.horrocks@torbay.gov.uk and copy to prp@torbay.gov.uk