******Young Person’s request for an Education Health and Care needs assessment**

***This document is a formal request for statutory assessment for an Education Health and Care Plan for the young person as outlined below.***

Please Tick:

*This has been written by the Young Person the request is being made for.*

*This has been written on behalf of the Young Person, with their permission and consent gained.*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of young person:** |  | | | | | **Date of request:** | | | | Click here to enter a date. | |
| **Date of birth:** | Click here to enter a date. | | | | | **NHS number (if known):** | | | |  | |
| **Your educational needs:** | **Please provide a brief description of your educational needs:**  **Please provide the reasons for requesting an EHCP assessment:**  **Do you have a specific diagnosis?**  If yes, please provide details: | | | | | | | | | | |
| **Education, training and qualifications:** | **Name** | **Level** | | **Type** | **Grade** | | | **Date achieved** | | | **Setting** |
|  |  | |  |  | | | Click here to enter a date. | | |  |
|  |  | |  |  | | | Click here to enter a date. | | |  |
|  |  | |  |  | | | Click here to enter a date. | | |  |
|  |  | |  |  | | | Click here to enter a date. | | |  |
| **Employment history:** | **Employer** | | **Job title** | | | | **Date finished** | | | **Date started** | |
|  | |  | | | | Click here to enter a date. | | | Click here to enter a date. | |
|  | |  | | | | Click here to enter a date. | | | Click here to enter a date. | |
| **Do you attend an educational setting?**  (please tick) | **If yes, please provide details:**  **Name of setting:**  **Address:**  **Contact number:**  **Please detail any other ‘further educational’ settings you have attended:** | | | | | | | | | | |
| **Please tick any health services that you are aware that you are known to:** | **Shropshire Community Health NHS Trust Services** | | | | | | | | | | |
| Diabetes Team | | | | | | | | Wheelchair Services | | |
| Physiotherapy | | | | | | | | Community Equipment Stores | | |
| Speech and Language Therapy | | | | | | | | CAMHS: | | |
| Occupational Therapy | | | | | | | | Others: | | |
| **Shropshire and Telford Hospitals NHS Trust Service** | | | | | | | | | | |
| Ophthalmology | | | | | | | | ENT | | |
| Others: | | | | | | | |  | | |
| **Other Acute NHS Hospitals and departments/consultants** | | | | | | | | | | |
| Birmingham Children’s | | | | | | | | Alder Hey | | |
| Others: | | | | | | | |  | | |
| **Shropshire and South Staffordshire Foundation NHS Trust Services:** | | | | | | | | | | |
| **Other Health Services including Independent Providers:** | | | | | | | | | | |
| **Do you currently receive any involvement or a service from Social Care?**  (please tick) | **If yes, provide name and contact details of your current social worker:** | | | | | | | | | | |
| **Do you access any other services such as ‘All-in’?**  (please tick) | **If yes please provide details:** | | | | | | | | | | |
| **Any additional information which you think may be useful:** |  | | | | | | | | | | |
| **Completed with the support of**  (If applicable) | **Name:  Relationship to young person:** | | | | | | | | | | |
| **Signature:** | **Date:** | | | | | | | | | | |

*Once completed please return with the* ***consent form, medical questionnaire and the all about me to: SEN Team, Shirehall, Shropshire Council, Abbey Foregate, Shrewsbury, SY2 6ND. Tel: 01743 254366***