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| --- | --- |
| Name of referrer:  | Job Title:  |
| Referring School name and address:  | Contact details: Phone: Email: Preference: |
| Pupil name:  | Year Group:  | D.O.B:  |
| Number of pupils in class:  | Local Authority:  |   |
|   |
| Does the pupil have autism?  | Yes | No |
| Does the pupil have any diagnosis?  | Yes | No |
| If yes, please provide details:  |
| Does the pupil have an EHCP?  | Yes | No |
| If yes, please provide details of primary need:    |
| Do they have any additional funding?  | Yes | No |
| Do they have access to 1:1 support?  | Yes | No |
| Is the pupil known to CAMHS?  | Yes | No |
| If yes, please provide details in what capacity:   |
| Is the pupil known to Children’s Social Care?  |   |   |
| If yes, please provide details in what capacity:   |
| Has the pupil had any fixed term exclusions?  | Yes | No |
| If yes, please provide details:   |
| Are they at risk of permanent exclusion?  | Yes | No |
| Please tick behaviours seen over the last 6 weeks and score them 1-5 using the scale below: 1. Daily
2. 2-3 times a week
3. At least once a week
4. On more than one occasion
5. Once over the last six weeks
 |
| Persistent disruption  |   | Verbal and aggressive language  |   | Physically aggressive towards peers  |   | Physically aggressive towards adults  |   | Stripping or behaviours impacting dignity  |   |
| Smearing behaviours  |   | Trashing and destructive behaviour   |   | Self-exiting  |   | Persistent task avoidance  |   | Criminal activity  |   |
| Other behaviours – please detail  |   |
| Are parents aware the request has been made?  | Yes | No |
| Will the school be able to share records and other information needed?  | Yes | No |
| Will SLT or inclusion team lead be available on the day of the visit to meet with the Fast Responder for up to 2 hours?  | Yes | No |
| Will the Fast Responder be able to observe the pupil across a number of settings in line with the pupils timetable?  | Yes | No |

Print name: Signed: Date:

**For internal use only:**

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| Date Received:  | Processed by:  | Referral No.  |
| Triaged by:  | Date of Triage:  |
| Activates Fast responder?  | Yes   | No  |
| Copy of feedback sent to applicant (Provide details) | Yes   | No  |
|       |
| Date SLA sent to school:  | Date SLA signed and returned:  |