**CONFIDENTIAL REQUEST FOR SERVICE SUPPORT**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pupil’s Name**  **D.O.B.** | | | **UPN** (required) | | | | | |
| **Year Group** | | | **Class Teacher / Form Tutor** | | | | | |
| **School** | | | **School Contact Name & Email** | | | | | |
| **Invoice Contact Name** | | | **Invoice Contact Email Address** (required) | | | | | |
| **Purchase Order Number** (required – please do not leave blank) | | | | | | | | |
|  | | | | | | | | |
| **Current SEN status**  **Please tick** | **No SEN** | | | | | | |  |
| **SEN Support** | | | | | | |  |
| **EHCP in place** | | | | | | |  |
| **EHCP application in progress** | | | | | | |  |
|  | | | | | | | | |
| **Service Requested**  **Please tick** | **Pupil Support Plan** | | | | | | |  |
| **Pupil Support Plan + Investigative Testing** | | | | | | |  |
| **Full Diagnostic Assessment** | | | | | | |  |
| **Full Diagnostic Assessment with DSA report (For KS4 & KS5)** | | | | | | |  |
| **Unsure - please contact to discuss further** | | | | | | |  |
|  | | | | | | | | |
| **Have any external agencies been involved/currently involved with the pupil?** |  | | | | | | | |
| **Family/ Medical history (if relevant).**  **Is there any medical diagnosis such as Autism, ADHD? Please tick** | **Autism** | | |  | | | | |
| **ADD / ADHD** | | |  | | | | |
| **SALT** | | |  | | | | |
| **OT** | | |  | | | | |
| **Mental Health** | | |  | | | | |
| **Other** | | |  | | | | |
| **Referred & on pathway for:** | | | | | | | |
| **Date of referral:** | | | | | | | |
| **Any further relevant details:** | | | | | | | |
| **Documents to attach if appropriate & available**  **Please tick** | **Educational / Clinical Psychologist report** | | | | |  | | |
| **Advisory / Specialist Teacher report** | | | | |  | | |
| **Paediatrician report** | | | | |  | | |
| **SaLT screening / report** | | | | |  | | |
| **OT report** | | | | |  | | |
| **Dyslexia screening** | | | | |  | | |
| **Other (please specify)** | | | | |  | | |
| **Has pupil’s vision and hearing been tested?** | **Date of last vision check:** | | | | | | | |
| **Date of last hearing check:** | | | | | | | |
| **Does the pupil wear glasses, have coloured lenses or use an overlay?** |  | | | | | | | |
| **Are there concerns regarding attendance?** |  | | | | | | | |
| **Key needs to be addressed** |  | | | | | | | |
| **Pupil’s strengths** |  | | | | | | | |
| **NB: if referring for diagnostic assessment, evidence of two cycles of an APDR response is required. Please attach - If this cannot be evidenced, please note the reason for this.** | | | | | | | | |
| **Current interventions** | **Frequency** | **Duration of intervention** | | | **Group/ 1-1?** | | **Outcome / Progress** | |
|  |  |  | | |  | |  | |
| **Previous interventions** | **Frequency** | **Duration of intervention** | | | **Group/ 1-1?** | | **Outcome** | |
|  |  |  | | |  | |  | |
| **Current level of attainment** | | | | | | | | |
| **Reading** |  | | | | | | | |
| **Writing** |  | | | | | | | |
| **Numeracy** |  | | | | | | | |
| **What are the desired outcomes from DOS involvement?** |  | | | | | | | |
| **If interventions are recommended by the specialist teacher, who will be able to carry these out or support their implementation?** |  | | | | | | | |

**Written parental consent is required for DOS involvement. Please see attached.**

**Fee agreement**: I acknowledge that this work is commissioned and an agreed fee will be paid to DOS for the work undertaken. (Please tick) 

Referral made by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Role \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

***Please attach a sample of the pupil’s work where possible.***

**Parent/Carer Consent for Dyslexia Outreach Service Involvement**

**Name of pupil: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your child’s school has requested involvement from the Dyslexia Outreach Service. This work may include some of, but not necessarily all of, the following:

* Discussion with people who already know the child/young person
* Access to relevant personal data held by school on that child/young person
* Classroom observation
* Individual/small group session with child/young person
* Investigative testing

Reports and action plans pertaining to this work will be kept securely and stored electronically by the Dyslexia Outreach Service for six years. A report or action plan resulting from DOS support will be shared with parents/carers of the child/young person and to the school who commissioned it.

Data, including your child’s unique pupil number, is collected and shared with DOS commissioners, Norfolk County Council, to enable analysis of:

* how the service is being used by educational settings,
* the range of services commissioned to support an individual pupil’s needs and
* the impact of the service on individual pupils’ special educational needs.

NCC processes, retains and destroys information securely in accordance with GDPR principles.

|  |  |  |
| --- | --- | --- |
| **Parent/Carer details** | | |
| Parent(s) / Carer(s) the child/young person is living with | | |
| Names(s): | Phone: | email: |
| Parent / Carer with parental rights (at a different address): | | |
| Name: | Phone: | email: |
| **Please inform us of any restrictions on parental contact.** | | |

* I give consent to the above named child/young person being supported by the Dyslexia Outreach Service. Please tick box for ‘yes’. 
* I give consent to details of the support given to the child/young person being shared with his/her school and NCC. Please tick box for ‘yes’. 

**Signature of parent/carer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***If you change your mind at any time about DOS involvement, you can let us know by contacting the child’s/young person’s school or DOS via the contact details below.***