**Leap to learn**

**Provider Referral Form**

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| **Pupil Information** | |
| **Full Legal Name:** |  |
| **Preferred Name:**  *(if applicable)* |  |
| **School Year:** |  |
| **DOB:** |  |
| **Address:**  *(including Postcode)* |  |
| **Statemented:** | Yes / No  *If yes, please provide details* |
| **LAC:** | Yes/ No  *If yes, please provide details* |
| **Contact number** |  |
| **Support Worker Information:** |  |
| **DSP** |  |
| **Additional Learning Needs:**  *(please highlight)* | ADHD  ASD  ODD  Mild Learning Difficulties  Moderate Learning Difficulties  Severe Learning Difficulties  Anxiety  Depression  Self -harm  Other *(please specify):*  *Please provide details:* |
| **Medical Issues / Requirements:**  *(please highlight)* | Asthma  Hayfever  Epilepsy  Diabetes  Allergies *(please specify):*  Food Intolerances *(please specify):*  Other *(please specify):*  *Please provide full details including information on any medication that needs to be dispensed in education hours (i.e. name of medication; when, who and how medication*  *will be dispensed):*  Health Care Plan required: Yes / No |
| **Brief Background:** *(including any other relevant information)* |  |

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| **Attendance Details** | |
| **Pattern of Attendance/Other Providers Attended:**  *(including days and times)* |  |
| **Proposed Start Date:** |  |