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**LOW INCIDENCE NEEDS SERVICE REQUEST FORM**

This form is for requesting involvement from the Low Incidence Needs Service at Hurworth Primary school. The attached Parent/Carer consent section must be completed.

|  |  |
| --- | --- |
| **What Service do you require? (Please tick ✓)** | |
| Hearing Impairment | Vision Impairment |
| Physical Needs Advisor |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **School Details** | | | |
| **Setting/school:** | | **Tel No:** | |
| **Email:** |  | | |
| **SENCo:** | | **Class Teacher:**  **Key worker:** | |
| **Sen Register / SEN Support / One Plan / EHC**  (please circle all that apply) | | | **Year Group:** |

|  |  |  |
| --- | --- | --- |
| **Child / Young Person Details:** | | |
| **Name:**  **Preferred name:** | **DOB:** | **Sex: M F** |
| **Address:** | | **Post code:** |
| **NHS Number:** |  | |
| **Name of Parent/Carer:** |  | |
| **Contact Number(s):** |  | |
| **In Local Authority Care?** | Yes | No |

**Reasons for referral** *(continue on additional sheets if required)*

|  |
| --- |
| **Nature of Impairment / Physical Disability / Diagnosis?** |
|  |

|  |
| --- |
| **What are your current concerns? Reason for Referral?** |
|  |
| **Other agencies involved currently?**  **e.g. Paediatrician, Consultants, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Early Years Inclusion Service, etc. Please provide names & contact numbers if possible.** |
|  |

**Medical Information (MUST BE completed if requesting HI or VI service)**

|  |
| --- |
| **Hospital:** |
| **Consultant:** |
| **Details of impairment (if known):** |

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

Please complete and attach the Parents’/Carers’ consent form (below) and return all pages to:

**Low Incidence Needs Service**

**Hurworth Primary School**

**Westfield Drive**

**Darlington**

**DL2 2ET**

**Telephone: 01325 720033**

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|  |  |
| --- | --- |
| **I agree to the involvement of the following service/s: (Please tick ✓)** | |
| Hearing Impairment | Vision Impairment |
| Physical Needs Advisor |  |

|  |  |  |
| --- | --- | --- |
| **Child/Young Person Details** | | |
| **Name of child/young person:** | **DOB:** | **Sex: M / F** |
| **Address:** | | **Post code:** |
| **Contact Number(s):** |  | |
| **Email Address:** |  | |

|  |
| --- |
| **Please tell us about your child’s needs:** |
|  |

|  |  |
| --- | --- |
| **I agree to the involvement of the Low Incidence Needs Service (Please tick ✓)** | |
| **Yes** | **No** |
| **I agree that advice or information about my child can be sought from and shared with other agencies involved with my child. (Please tick ✓)** | |
| **Yes** | **No** |
| **I agree for my child to be seen in their education setting without parental presence. (Please tick ✓)** | |
| **Yes** | **No** |

|  |  |
| --- | --- |
| **Signed:** | **Date:** |
| **Print Name:** | **Relationship to child:** |

**Please return the completed form to**

**Low Incidence Needs Service**

**Hurworth Primary School**

**Westfield Drive**

**Darlington**

**DL2 2ET**

**Telephone: 01325 720033**