# MEDICAL TUITION SUPPORT SERVICE

## Consultant Referral Form 1

**This form is to be completed by CAMHS Practitioner/Community Paediatrician/Psychologist/Occupational Therapist/Consultant.** **NOT TO BE COMPLETED BY SCHOOL, PARENT OR GENERAL PRACTITIONER**

| | | |
|---|---|---|
| **Student Name:** | **DOB:** | **Age:** |
| **School:** | **Year Group:** | |

Current Medical Condition:

Current Medical Input or Treatment:

Date Last seen:

Is the student well enough to receive some education Yes/No
In your opinion how many hours **in TOTAL** per week is he/she able to access? ☐ (max.5hrs offered per week)

Ideal maximum session length ☐

Is this student well enough to attend normal classes within their mainstream school YES/NO

If so, How many hours -

If the student is **UNABLE** to attend normal classes in school is he/she
a) Well enough to be taught 1:1 in a small/ quiet room on their school site Yes/No
b) Well enough to leave home to attend a venue other than their school Yes/ No

If the student is **NOT** well enough to attend school in your opinion for how long should tuition be provided:

6 weeks - ☐ (Standard period of support offered)

12 weeks - ☐ (Please note that any extended periods of support will only be offered in exceptional circumstances)

In your opinion when would you expect the student to be able to access 10 or more hours in their mainstream school?

Please give any guidance on the rate of reintegration:

**Name:** **Role:**

**Signature:** **Date:**

- Signature confirms permission has been sought from parents/carers to share this information