MEDICAL TUITION SUPPORT SERVICE

Referral Form 1

This form is to be completed by CAMHS Practitioner/Community/Paediatrician/Psychologist/Occupational Therapist/Consultant. This can also be completed by school, parent or general practitioner with supporting medical evidence

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		
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