



PARENT, CARERS OR YOUNG PERSONS REQUEST FOR A STATUTORY EDUCATION, HEALTH AND CARE ASSESSMENT

Please complete all parts of this form before sending.

If parents, carers or young people are unable to complete this form, they should phone or email the START (Statutory Assessment and Review Team) 0121 704 6690 or email edsen@solihull.gov.uk

DETAILS OF CHILD/YOUNG PERSON	
Child's/Young Person's Name:	Date of Birth:
Current Setting/School	NC Year Group:
Age:	

CURRENT NATIONAL CURRICULUM LEVELS OR P SCALES (If known)	
Maths	
Reading	
Writing	
Speaking and Listening	

Please indicate the primary area(s) of need identified: Please prioritise (1, 2 - primary/secondary need):							
Cognition and Learning		Communication and Interaction		Social, Emotional and Mental Health		Physical/Sensory/ Medical	
Moderate learning difficulties		Speech & language difficulties		Social difficulties		Physical difficulties	
Specific learning difficulties		Autistic Spectrum Disorder		Emotional difficulties		Visual impairment	
Severe learning difficulties		Social communication difficulties		Other SEMH (Social Emotional Mental Health) Difficulties		Hearing impairment	
Profound & multiple learning difficulties				ADD/ADHD		Medical difficulties	

REASON FOR REQUEST

Explain the reason for requesting this EHC assessment

You should consider the following areas:

Education and learning - for life and work:

Communication and interaction:

Friendships, and relationships:

Social, emotional & mental health needs:

Independence:

Physical, sensory and health needs:

Support for the family:

**Which of these services has been working with the child/young person?
e.g. Specialist Inclusion and Support Service (SISS)**

	Name of Professional and contact details	Date(s) of involvement	Report included? (Y/N)
SISS CLD Team (Children with Learning Difficulties)			
SISS ASD Team (Autistic Spectrum Disorder)			
SISS SEMH Team (Social Emotional Mental Health)			
Other SISS Team			
Educational Psychologist			
Community Paediatrician			
Speech and Language Therapy Service			
Paediatric Occupational Therapy Service			
Paediatric Physiotherapy Service			
Child and Adolescent Mental Health Service (CAMHS)			
Other – Please list below			

REFERER	
Name of person submitting the request	
Address	
Phone	
Email Address	
Relationship to child/ young person:	
Signature	
Date	

PARENT/CARER CONSENT
<p>I/We give consent for the LA to request further info from School.</p> <p>I/We confirm that I/We have read and understood all of the information included in this request. I/We certify that the information, which I/we have provided, is correct.</p> <p>I/We understand that the information provided in this application will be used to ensure that the council's records are correct. It may also be shared with other agencies and service providers to ensure that your son/daughter receives an appropriate service.</p> <p>Signature of parent/carer..... Date.....</p> <p>Signature of parent/carer..... Date.....</p>

Return to:

**Statutory Assessment and Review Team
 Learning Skills and Progression
 Council House
 Manor Square
 Solihull
 B91 3QB**