

Email: **education@adoservices.co.uk**

Website: [**www.adorivervalley.co.uk**](http://www.adorivervalley.co.uk)

**Once complete please attach any relevant documents and return securely to the email stated above.**

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| **ADO Education Referral Form** |

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| Referrer Details |  |
| **Name:** | **Job Title:** |
| **Agency:** | **Address:** |
| **Telephone:** | **E-mail:** |
| **Date of Referral:** | **Is this Referral to ADO:**  A Short-Term Interim Placement (up to 6 months)  A Medium-Term Placement (6 months-1 year)  A Long-Term Placement (1 year- full education duration, which could include Post-16) |
| **How long have you worked with the Young Person?** *(Please tick)*  Less than 6 months  1-2 years  6 months to 1 year  More | **In what capacity?** *(Please tick)*  Local Authority  Teaching Professional/Current School  CAMHS    Fostering Agency  Social Worker  Other (*please Specify)*: |

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| Student Details | |  | |
| **Mr/Miss/Other:**  **First Name:** | | **Surname:** | |
| **Date of Birth:** | | **Telephone:** | |
| **School Year:** | | **Key Stage:** | |
| **Ethnicity** *(Please tick all which apply)***:** | |  | |
| White |  | Black or Black British |  |
| British |  | Caribbean |  |
| Irish |  | African |  |
| Any other white background |  | Other Black or Black British |  |
| Asian or British Asian |  | Other ethnic background |  |
| Indian |  | Chinese |  |
| Pakistani |  | Mixed ethnicity Other |  |
| Bangladeshi |  | Other *(please specify below)* |  |
| Not Declared |  |  |  |
| **Address:**  **Postcode: BR6 8PN** | | **Student’s UPN**: | |
| **Student’s ULN**: | |
| **Is This Child-Young Person Under:**  *(Please tick where applicable)*  Social Worker  Looked After Child (LAC)  Child In Need (CIN)  Sibling on Child Protection  Child Protection (CP)  Other: *Please State* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please send any supporting documents at the time of referral.** | | | |
| **Does this student have a Safety Plan?**  Yes  No  Unsure  If ‘Yes’, please send the safety plan with the referral and any other supporting documents. | | | |
| **Please list previous education placement/school or current home school for dual roll purposes. Please also include duration of attendance at that setting, and what subjects the student is taught at the setting:**  **Please send the child/young person’s latest education report to assist us with forming a baseline for this student.** | | | |
| **Do you have access to the student’s last attendance record?**  Yes  No  *If ‘Yes’, please send a copy of the attendance record along with the referral.*  **If ‘No’ please advise who we can contact to obtain this**: | | | |
| **In your opinion, why would this child-young person benefit from our Outdoor Education Services?** | | | |
| **Which educational qualifications is the child-young person interested in?** *(Please tick)*  Animal Care (KS3/4/KS5(Post16): AQA Awards or BTEC)  Equine Studies (KS3/4/KS5(Post16): AQA Awards or BTEC)  Countryside & Environment (KS3/4/ KS5 (Post16): AQA Awards or BTEC)  Sport Activity & Fitness, Sport Leadership, Outdoor Sport (KS3/4/ KS5 (Post 16): AQA Awards or BTEC)  Functional Skills (Maths/English): Entry Levels 1/2/3, and Level 1 and 2  *The curriculum has a range of subjects and awards that YP can study, covering the Independent Framework including basic numeracy and literacy.* | | | |
| **How does this referral link with their current education plan and reintegration to mainstream school, where appropriate?** | | | |
| **In your opinion, have any specific education interventions or strategies and/or psychological interventions been helpful in supporting this child-young person?** | | | |
| **Would this child-young person benefit from any specific embedded therapeutic workshops to increase their emotional resilience, well-being and coping skills?**  Yes  No  Unsure  *If ‘yes’, please tick below which ones;*  Managing Stress  Managing Depression  Managing Anger  Managing Anxiety  Developing Social Skills    Our model provides a combination of Cognitive Behaviour Therapy, Relaxation Therapy, Animal Therapy and Occupational Therapy to suit the needs of the child/young people and support the students’ wellbeing. | | | |
| **How many days provision per week are required at this stage?**  **Which days would be ideal for consideration around the student’s current schedule?** | | | |

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### Clinical Details

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| **Does the student have an Education and Health Care Plan?**  *If ‘Yes’ please attach a copy of the care plan and send securely*  Yes  No  In Progress  **Does the student have an Educational Psychologist Report?**  *If ‘Yes’ please attach a copy of the report and send securely*  Yes  No  In Progress |
| **Does the child-young person have any Medical Diagnosis?**  Yes  No  If ‘yes’, please detail:  **Does the child-young person require any medication administered during the school day?**  Yes  No  Unsure  If ‘yes’, does the child-young person experience any side effects with this medication?  Yes  No  Unsure |
| **Please give a brief description of the student’s mental health or behavior**: |
| **Please give details of any intellectual difficulty or disability**: |
| **Please give details of any communication needs *(speech/language/hearing/sight)***: |
| **Please give details of any physical difficulties** *(strength, stamina, motor skills, mobility)*: |
| **Please detail any additional information which may be relevant, including family background**: |
| **Does the child-young person have up to date tetanus cover?**  Yes  No  Unsure |
| **Does the student have a history in any of the following:** *(Please tick)*  **Self-harm or suicidal behaviour?**  Yes  No  Unsure  **Violence/ abusive behavior towards other students?**  Yes  No  Unsure  **Violence or abusive behavior towards staff?**  Yes  No  Unsure  **Violence or abusive behavior towards animals?**   Yes  No  Unsure  **Arson?**  Yes  No  Unsure  **Absconding from school?**  Yes  No  Unsure  **Convictions as a young offender?**  Yes  No  Unsure  **Alcohol or drug misuse?**  Yes  No  Unsure  If any of the above applies please detail below: |
| The following is in relation to deterioration in the student’s mental health.  **Please list any early warning signs/triggers**:  **How do you feel ADO can best support the student in the short term?**  **How do you feel ADO can best support the student in the long term?**  **How would your client like us to support them if their mental health was deteriorating?**  ***Note: If there are any changes with the student’s mental health or medication, the referring organisation or parent-carer would be required to let us know as soon as possible.*** |

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| **Emergency contact details for the student:**  **Name**:  **Relationship**:  **Mobile Telephone**:  *(We use SMS or telephone calls to keep parent-carers up to date on their child/yp as required so please provide a phone number where permission is granted for both SMS and calls during the school day)*    **E-mail**:  *If the parent/carer that resides with the child/YP has any known additional needs or any information we should be aware of in order to support the family when liaising with them about their child/YP, please detail this here:* |

Assessment

BILLING INFORMATION:

**Who will be funding the assessment/placement?**

Local Borough  School  Other *(Please Specify)*:

Invoicing Contact Name:

Invoicing Contact Job Role:

Invoicing Contact Phone Number:

Invoicing Email Address for E-Billing:

Invoicing Client Address for System Purposes:

*Please Note: All billing fields require completion for system setup and assessments to be booked.*

*The assessment consists of a digital form which is to be completed prior to us meeting the individual. This is classed as ‘Stage 1’ of our assessment process, followed by ‘Stage 2’ which is a two-day practical assessment. Please provide contact details for the most relevant person/s to undertake each part of the assessment.*

**Digital Assessment form:** *Our preference is for parent or care giver to complete this, as we have an understanding of professionals viewpoint from this form. However, in some cases we know this is not feasible and therefore please list the most relevant adult:*

Name:

Relationship/Role:

E-mail:

**Practical Assessment**

*(Maximum two adults; recommended one professional and one parent-carer).*

*The supporting adults will be required for the first 2 hours of the first day assessment. If the student settles within this time, the student is able to remain on site until the end of the school day. This allows staff to assess engagement and affirm we can safely meet their needs in the outdoor setting, before meeting them again for the second day.*

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|  | **Adult 1** | **Adult 2** |
| Name: |  |  |
| Relationship/Role: |  |  |
| Telephone: |  |  |
| E-mail: |  |  |

**Referrer’s Name - Signature:**

(Please note typed names will constitute signature for online referrals)

**Date:**

Thank you for completing the ADO Education referral form.

Please send this referral and any supporting documents, such as EHCP, CIN plans, Safety plans, to:

[**education@adoservices.co.uk**](mailto:education@adoservices.co.uk)

If you have any questions, please call **020 8850 6778**

A member of the team will be in touch with you shortly.

Office hours 8.30 until 5pm

***The River Valley Alternative Provision part of***

***ADO Services CIC. – A Not For Profit Community Interest Company***