|  |  |  |
| --- | --- | --- |
| **Health Advice to Inform EHC Needs Assessment** | | |
| **Learner’s Name** | **Date of Birth** | **NHS No.** |
|  |  |  |
| **Name of professional providing advice** | **Designation** | **Date** |
|  |  |  |
| **Email** | **Telephone Number** | **Address** |
|  |  |  |

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| **SECTION C: IDENTIFIED HEALTH NEEDS** |
| **Confirmed medical diagnoses:** |
|  |
| **Do the learners identified health needs result in a Special Educational Needs? E.g., a barrier to their learning?**  Yes  No |
| **If yes,** please describe how their health needs impact on their ability to access learning |
| **Does the learners identified health needs result in wider implications for an education setting? E.g., the need to administer medication or implement of a posture management programme.**  Yes  No |
| **If yes,** please describe the implications their health needs present for an education setting and what support may be needed to manage the learners medical needs. |

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| **Summary of Involvement** | | | | |
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| **SECTION E: OUTCOMES SOUGHT FOR THE LEARNER** | | | | |
| **In considering what is important for the learner, please specify outcomes sought for the learner. Outcomes should be SMART and linked to the learner’s aspirations.**  (E.g. By the end of this key stage, Ralph will initiate a conversation with a peer at least once per week during mainstream lesson without any adult prompts.) | | | | |
| **Longer term outcomes:** | | | | |
| **1.** | The learner will be able to… |  | **By when:** |  |
| **2.** | The learner will be able to… |  | **By when:** |  |
| **3.** | The learner will be able to… |  | **By when:** |  |

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| **SECTION G: HEALTH PROVISION** | | | | |
| Is an Individual Health Care Plan in place? *e.g. epilepsy plan, asthma plan, diabetes plan* | | Yes  No  Not Known  **If yes,** please attach. | | |
| Does the learner receive a Continuing Care package? | | Yes  No | | |
| **If yes**, please provide details | | | | |
|  | | | | |
| Does the learner require any specialist equipment? | | Yes  No | | |
| **If yes**, who will provide this? | | | | |
|  | | | | |
| What support is required from the core commissioned service? | | | | |
|  | | | | |
| **Type of support/provision.**  **What is the health provision required?**  *Please detail provision above and beyond core commissioned services* | **Timescales/**  **frequency**  *How often will this happen and for how long?* | | **Who will provide this support?** | **Has this provision been approved by the CCG Commissioner?** |
|  |  | |  | Yes  No |
|  |  | |  | Yes  No |
|  |  | |  | Yes  No |
|  |  | |  | Yes  No |
|  |  | |  | Yes  No |
|  |  | |  | Yes  No |
|  |  | |  | Yes  No |
|  |  | |  | Yes  No |

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| **SECTION J: PERSONAL BUDGET AND DIRECT PAYMENTS** |
| **Is the child/young person/family in receipt of a personal budget or direct payment?**  Yes / No / Unknown |
| **What does the personal budget or direct payment provide for the child/young person/family?**  *Please detail the type and quantity (in hours) of support that this funding provides.* |

Please return to the Local Authority, as a **Word** file.

**By post:** SEND Assessment & Review Team, Hull City Council, 79 Lowgate, Hull, HU1 1HP

**By the EDT**

**By SFX secure e-mail:** [SEND@hullcc.gov.uk](mailto:SEND@hullcc.gov.uk)