**Young Person’s request for an Education Health and Care needs assessment**

***This document is a formal request for statutory assessment for an Education Health and Care Plan for the young person as outlined below.***

Please Tick:

[ ]  *This has been written by the Young Person the request is being made for.*

[ ]  *This has been written on behalf of the Young Person, with their permission and consent gained.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of young person:** |  | **Date of request:** | Click here to enter a date. |
| **Gender** |  | **Preferred Pronoun****(eg. They/them She/her He/him)** |  |
| **Date of birth:** | Click here to enter a date. | **NHS number (if known):** |  |
| **Your educational needs:** | **Please provide a brief description of your educational needs:****Please provide the reasons for requesting an EHCP assessment:****Do you have a specific diagnosis?** [ ]  If yes, please provide details: |
| **Education, training and qualifications:** | **Name** | **Level** | **Type** | **Grade** | **Date achieved** | **Setting** |
|  |  |  |  | Click here to enter a date. |  |
|  |  |  |  | Click here to enter a date. |  |
|  |  |  |  | Click here to enter a date. |  |
|  |  |  |  | Click here to enter a date. |  |
| **Employment history:** | **Employer** | **Job title** | **Date finished** | **Date started** |
|  |  | Click here to enter a date. | Click here to enter a date. |
|  |  | Click here to enter a date. | Click here to enter a date. |
| **Do you attend an educational setting?** (please tick)[ ]  | **If yes, please provide details:****Name of setting:****Address:****Contact number:****Please detail any other ‘further educational’ settings you have attended:** |
| **Please list any health services that you are aware that you are known to:**Eg CAMHS,Physiotherapy,Speech and Language Therapy |  |
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| **Do you currently receive any involvement or a service from Social Care?**(please tick)[ ]  | **If yes, provide name and contact details of your current social worker:** |
| **Any additional information which you think may be useful:** |  |
| **Completed with the support of**(If applicable) | **Name:Relationship to young person:** |
| **Signature:** |  **Date:** |

*Once completed please return with the* ***consent form, medical questionnaire to the SEN team***

***senteam@dudley.gov.uk***

***SEND Team, Ladies Walk Centre, Ladies Walk, Sedgley, DY3 3UA.***