

**Referral form for Independent Support East and West Sussex**

This form is intended for professionals to make a referral to the Independent Supporter Service. If you are a parent/carer or young person and would like an Independent Supporter then you should ring **0300 123 7782** or email is@amazebrighton.org.uk

Thank you for considering making a referral for Independent Support. This service is for parent carers and/or young people during the process of assessment for an Education, Health and Care (EHC) plan. We are funded by the government to ensure that families have all the information and support they need to fully engage in the assessment process and can obtain the best possible EHC Plan.

All parent carers and young people (16-25) are entitled to an Independent Supporter although the level of service we offer may vary according to their needs and wishes. We can meet families in their homes but we can also offer support by phone and email. There is a leaflet explaining more about Independent Support which can be downloaded from our website [www.amazebrighton.org.uk](file:///%5C%5Cserver1%5CDesktop%5Ccharlotte.moroney%5CDesktop%5Cwww.amazebrighton.org.uk) or ask us for a copy.

Families engaging with our service will have a named Independent Supporter who has undertaken specialist training on EHC Plans from the Council for Disabled Children and holds an enhanced DBS.

The information you provide on this referral form will help us to match the most appropriate support. Support is available either for transfers from a Statement of Special Educational Needs to an EHC plan or for the preparation of a new EHC plan.

Please ensure that you have consent to male a referral to the Independent Support Service.. When you have completed this form please email it to: is@amazebrighton.org.uk

Please note that that if a young person (16-25) and their parent/carer have requested separate independent supporters you should make separate referrals for each of them.



**Referral Form for Independent Support**

**Your name and contact details:**

|  |  |
| --- | --- |
| **First Name:**  |  |
| **Surname:** |  |
| **Telephone:** |  |
| **Email:** |  |
| **Role / Service:** |  |

**Who are you referring?** (Please delete as appropriate) Parent/Carer or Young Person age 16-25 with Special Educational Needs / Disability

**Their contact details:**

|  |  |
| --- | --- |
| **First Name:** |  |
| **Surname:** |  |
| **Address:** |  |
|  |  |
| **Postcode** |  |
| **Home Telephone:** |  |
| **Mobile:** |  |
| **Email:** |  |

**Their preferred method of contact:** (Please delete as appropriate) Face to face / Email / Telephone / Text Message

**Child or Young Person’s Details (if not given above):**

|  |  |
| --- | --- |
| **First Name:** |  |
| **Surname:** |  |
| **Address** |  |
| **Postcode** |  |
| **DOB:** |  |
| **Age:** |  |
| **Name of Education Provider** |  |
| **School year:** |  |

**Child or Young Person’s Additional needs:**

**Has a new EHCP been requested?** (Please delete as appropriate) Yes / No

**Date the statutory process started (if known):**

**Is this a transfer from a Statement?** (Please delete as appropriate) Yes / No

**Date of transfer meeting or next annual review (if known):**

**Please tell us more about reasons for this referral**:

Please include information about the individual or family circumstances that will help us offer an appropriate service e.g. if parent care literacy difficulties or other additional needs, if there are any other siblings with additional needs, if the child is Looked After, if the child has been excluded or is not attending school/college etc.)

**Details:**

**Have you got their permission from the parent or young person to share the information on this form with the Independent Support Service?** (Please delete as appropriate) Yes / No

**For office use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of referral: |  | Source of Referral: |  |