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| **AAC WEST****(Augmentative and Alternative Communication****West of England Specialised Team)****Education Consultation Referral Form** **Expectations**In order to achieve an effective consultation, it is vital that the patient and the team around the patient work closely together, and that the expectations for the consultation process are understood and agreed prior to referral. **What is expected from the patient using the service?*** To attend all agreed appointments, where appropriate and when applicable. (It may not be necessary for the patient to be present throughout the whole appointment)
* To work towards outcomes and recommendations that are made as part of the consultation

**What is expected of the setting completing the referral?*** To complete the Education referral form, and provide relevant information in support of the referral
* For appropriate staff to be released from class to attend any relevant parts of meetings
* To support the patient to participate and contribute during appointments
* To liaise with all appropriate local professionals involved in the patient’s care
* To attend any recommended training
* To work with AAC WEST and plan a cycle of intervention following a Plan, Do, Review approach

**What can you expect from AAC WEST, Educational Consultation?*** A comprehensive, patient centred consultation within the educational setting.
* Appointments arranged at times to suit the patient, and other professionals
* Advice on how to implement AAC systems across the curriculum within an educational setting
* Setting and reviewing outcomes with the patient and their team
* Comprehensive summary reports
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| **Patient Information** |
| **Full Name of Patient (child or young person):** | **Date Of Birth:** |
| **Male/Female:** | **Age:** | **Year Group:** |
| **Home Language:** | **Ethnicity Code:** (please ask the patient to indicate which code best matches their heritage/identity. See the list at the end of the form). |
| **Names of Parents/Carers:** *(If patient is in care please state who has parental responsibility)* | **Contact Details:**Home Tel:Mobile:Email:  |
| **Patient’s Home Address:****Post Code:** |
| **Is the patient in the Public Care?** Yes [ ]  No [ ]  | **Additional Adults with Parental Responsibility:**Name:Address: |
| **Medical Diagnosis:**  |
| **EHCP** Yes/No |
| **Professional Information**  |
| **Name of professional making the referral:**  |
| **Relationship with the patient:** (Teacher, SENCO, SLT etc) |
| **Address:** |
| **Telephone:**  |
| **Email:**  |
| **Names of other professionals involved:** (SENCO, Class teacher, Teaching assistant/ key worker etc) |
| **Name & Role** | **Email address** | **Contact telephone number** |
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| **School Information** |
| **Current School/Setting:** |
| **Level of support**(1:1 teaching assistant / key worker/ full time / part time, class TA etc) |
| **Name of key contact email address, if different from above:** |
| **AAC Equipment and Resources** (please give details):**High tech in place and frequency of use throughout the day:****Low tech in place and frequency of use throughout the day:** |
| **Request for Specialist Educational involvement**  |
| **Who has requested this referral and why?** (Please explain how this referral fits in with any educational outcomes)**What outcomes do you hope will be achieved as a result of the Education Specialist’s involvement?** Please give detail |

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| **Educational Attainment and Curriculum Access** (Information required) Please include examples**.**  |
| **Curriculum information:** (What curriculum is the patient following?)  |
| Please comment on the following:**Literacy** **Phonics:** (phase and understanding)**Writing**: (Emergent writer/ conventional learner/ methods of recording/ alternative pencil/ scribe etc) **Reading Framework**: (Emergent reader/ conventional learner) Include level of reading e.g. words/phrases/sentences/paragraphs**Symbol knowledge** (symbol set used**)**  |
| **Listening and Attention skills, Cognitive ability:** including long and short term memory, concentration, attention, following instructions and their ability to learn new skills. |
| **Comprehension:** Including level at which able to follow conversation and tools required to support understanding of spoken language, key word level of understanding, include formal/informal assessment findings |
| **Expressive Language (**Including use of Low tech and high Tech AAC)**Examples of expressive language** (using any mode of communication) |
| **Sensory Needs:**  |
| **Social Interaction:**  |
| **Any additional comments:**  |

**Consent**

| **Consent:** Has the patient consented to this referral?Please detail how the patient gave their consent. (Verbally, using AAC, gesture etc.)  | Yes [ ]  No [ ]  |
| --- | --- |
| Has someone consented on behalf of the patient?Name:Relationship to patient:Reason consent not gained from patient: | Yes [ ]  No [ ]  |
| **Consent:** Does the patient consent to be contacted by email?*Please be aware that confidentiality cannot be guaranteed, and the NHS is not liable for the confidentiality or security of any message once it’s been sent*. | Yes [ ]  No [ ]  |

| Have you discussed and agreed the expectations of the AAC WEST appointment with:  |
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| The patient?Yes [ ]  No [ ]  | The patient’s family?Yes [ ]  No [ ]  | The team around the patient?Yes [ ]  No [ ]  |
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**Once completed this form should be returned to your area base including**

INFORMATION AND CONSENT FROM PARENT/S OR CARERS

I consent to the Specialist Educational Professional from AAC WEST becoming involved with (name of patient) or I understand this may involve consulting school staff and other professionals, observing, talking to, and working with my child.

**Information sharing**

I give consent for information and reports regarding the health and wellbeing of (name of patient) to be shared with the AAC WEST and the school setting, including information about appointments, the results of testing, diagnoses, and medical reports.

I consent to the information held on this file being shared with other relevant professionals such as teachers, health and social workers, to inform their work.

Please be aware that without your consent the Specialist Educational Professional is

unable to have any involvement.

Name of patient (child or young person) …………………………………………………………………….

Name of parent / carer …………………………………………………………………...............

Signature…………………………………………………………………………………………..

Date…………………………….

**Please complete all sections of this referral form and email to:** **aacwestadmin@nbt.nhs.uk**

If you have any queries, please contact AAC WEST on 0117 4145850

Signed:

Name:

Date of Completion:

**Ethnicity code:**

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| A | White – British  | K | Asian or Asian British – Bangladeshi |
| B | White – Irish  | L | Asian or Asian British - any other Asian background |
| C | White – Any other white background | M | Black or Black British – Caribbean |
| D | Mixed – White and Black Caribbean | N | Black or Black British – African |
| E | Mixed – White and Black African | P | Black or Black British – Any other Black background |
| F | Mixed – White and Asian | R | Chinese |
| G | Mixed – Any other mixed background | S | Any other ethnic group |
| H | Asian or Asian British – Indian  | Z | Does not wish to disclose |
| J | Asian or Asian British – Paskistani |  |  |