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| **Speech and Language Therapy Advice** |
| This advice is to inform: EHC Needs Assessment [ ]  Annual Review of EHC plan [x]  |
| **SEND Caseworker** | **Date Sent** | **Date Response Due**  |
| **Helen Leadley**  |  |  |
|  |  |  |
| **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/clinical diagnoses** |
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| **Any identified health needs relating to special educational needs** |
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| **Professional’s Report** |
| **Brief details/summary:** |
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| **Strengths:** |
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| **Areas for development:** |
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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.** |
| **Longer term outcomes:**  |
| **1** |  | **By when:** | End of Key Stage # |
| What difference will this make? What will be the impact? |  |
| **2** |  | **By when:** |  |
| What difference will this make? What will be the impact? |  |
| **3** |  | **By when:** |  |
| What difference will this make? What will be the impact? |  |
| **4** |  | **By when:** |  |
| What difference will this make? What will be the impact? |  |

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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 [ ]  Not Known [x]   |
| **If yes**, please provide details |
|  |
| Does the learner require any specialist equipment? | Yes [ ]  No [ ]   |
| **If yes**, who will provide this? |
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| **What support is required from the core commissioned service?** |
| **Type of support/provision.****What is the health provision required?** | **Timescales/****frequency***How often will this happen and for how long?* | **Who will provide this support?** |
| *E.g. Devising and review of communication plan.* | *Minimum of annually.* | *Speech and Language Therapy Service* |
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| **Other support recommended?** |
| **Type of support/provision.** | **Timescales/****frequency***How often will this happen and for how long?* | **Who will provide this support?** |
| *E.g. Implementation of a communication plan on a 1:1 basis to support the development of speech, language and communication devised by a Speech and Language Therapist.* | *Daily for 15 minutes* | *Education staff with advice from a Speech and Language Therapist.* |
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**Cc Parents Setting SEND Team**