

**COMMUNICATION LANGUAGE AND AUTISTIC SPECTRUM SUPPORT
(C.L.A.S.S)**

1) **ACTION + REFERRAL FORM**

Name of Pupil		
Date of Birth		NC Yr:
Parents/Guardians Names		
Address		
Postcode		
Tel. No:	Home:	Work:
School		
Contact Person/SENCo		
Class/ form teacher/ Head of Year		
Educational Psychologist		
Speech & Language Therapist		
Any other Professional Involvement eg Paediatrician/ social worker/ Psychiatrist etc <i>(please give names and title)</i>		
Medical Diagnosis		
Any other relevant medical history		
Please tick the boxes to confirm that you have attached the following information or explain why it is not available		
<ul style="list-style-type: none"> • 2 reviewed IEP's reflecting the areas of concern • % Attendance in past 3 terms- (print out) • National Curriculum/ P levels inc. PSD descriptors • Recent report from at least one of the following: <ul style="list-style-type: none"> Educational Psychologist Speech and Language Therapist Other medical professional Other Educational service 	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

Particular Strengths: What are the positive things you notice about this child?

Current Concerns: What do you perceive to be the child's main needs?

Strategies already in place: What are you currently doing to help the child?

CLASS Involvement: What would you hope to receive from CLASS

<p>Referral made by:</p> <p>Post Held:</p> <p>Date:</p>	<p>I give permission for a referral to be made to CLASS for my child.</p> <p>Signed: Parent/Carer</p> <p>Date:</p> <p>Would you like to add anything else to this application?:</p>
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Please return to Marilyn Brown at the address below: