

**Referral form for Independent Support at Amaze**

**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 9186 or email [independentsupportwsx@amazebrighton.org.uk](mailto:independentsupportwsx@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. It is intended for parents and /or young people who would find it helpful to have extra support to allow them to take part fully in the EHC plan process. There is a leaflet explaining more about Independent Support which can be downloaded from our website [www.amazebrighton.org.uk](file:///\\server1\Desktop\charlotte.moroney\Desktop\www.amazebrighton.org.uk) or ask us for a copy.

We will look at each referral to see whether an offer of Independent Support can be made and the level of support to offer. Where Independent Support is not appropriate (e.g. not currently in the process of EHC needs assessment or plan writing) we should be able to offer other help from Amaze’s Information, Advice and Support (IAS) service.

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.

If you are referring someone else you must discuss this referral with them before sending it to us. When you have completed this form please email it to: [independentsupportwsx@amazebrighton.org.uk](mailto:independentsupportwsx@amazebrighton.org.uk)

Please note that that if the young person 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:** |  |

**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:** |  |
|  |  |
| **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:** |  |
| **DOB:** |  |
| **Age:** |  |
| **Name of School:** |  |
| **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:**

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

**Date of transfer meeting or next annual review:**

**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 parents/ carers have disabilities, 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: |  |