# **Education Health and Care (EHC) Needs Assessment Health Advice**

This information is sought in accordance with the Children and Families Act 2014. The Local Authority is seeking advice as part of an Education, Health, and Care needs assessment.

**Please indicate the type of advice you are requesting.**

Education Health Care (EHC) Information and Advice

Education Health Care (EHC) Plan Annual Review

## **1. Personal Information**

### Child/young person’s details

**Name:** Click or tap here to enter text.

**Gender:** Click or tap here to enter text.

**Date of birth:** Click or tap to enter a date.

**Age:** Click or tap here to enter text.

**NHS Number:** Click or tap here to enter text.

**Ethnicity:** Click or tap here to enter text.

**Home address:** Click or tap here to enter text.

**Contact details:** Click or tap here to enter text.

**School/education placement:** Click or tap here to enter text.

**GP name/practice:** Click or tap here to enter text.

**Looked After/In Care:** Click or tap here to enter text.

**Subject to child protection plan:** Click or tap here to enter text.

**Known to Children’s Social Care:** Yes  No  Not known

**Known to Adult Social Services:** Yes  No  Not known

**Continuing Care/Continuing Healthcare:** Yes  No  Not known

**Known to PfAL (Preparing for Adult Life Team NCC):** Yes  No  Not known

### Parent/carer details

| **Information** | **Parent/Carer 1** | **Parent/Carer 2** |
| --- | --- | --- |
| **Name** |  |  |
| **Relationship to child/young person** |  |  |
| **Parental responsibility** | Yes / No | Yes / No |

### Professional advice giver’s details

**Clinician’s name:** Click or tap here to enter text.

**Clinician’s title/designation:** Click or tap here to enter text.

**Service contact address:** Click or tap here to enter text.

**Service telephone number / service email address:** Click or tap here to enter text.

**Date advice written:** Click or tap to enter a date.

## **2. Views of the child/young person and their parents/carers**

**Please indicate if you have had access to a copy of the Family Conversation Form.**

Yes  No

**Please document the views, interests and aspirations of the child/young person.**

**Please document parent/carer views and their aspirations for the child/young person.**

**Has this advice been completed with the child/young person and their parents/carers?**

Yes  No  (*If no, please give reasons why this has not been possible.)*

**Has a copy of this advice been shared with the child/young person and their parents/carers?**

Yes  No  (*If no, please give reasons why this has not been possible.)*

## **3. Medical information**

| **Medical diagnosis or medical conditions** | **Who made the diagnosis? Name and organisation** | **Date diagnosis given** |
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**Background information.** Please include a brief summary of the Clinician’s involvement to date and relevant medication/treatment

**When did you last see the child/young person?** Please provide a date and where the appointment took place eg clinic, virtual, school etc

**Medical professionals involved.**

**Referrals to other services.** Please identify any referrals that have been made from your service to other health/therapy services for this child/young person.

**Preparation for adult life.** If the young person is 14 or above, what has been implemented to transition the young person to adult services where appropriate and prepare them to care for their health in adult life?

**What is working well for this child/young person for their health?** (For example, Charlie has difficulties with fine motor skills, but he is responding well to the occupational therapy provision we are putting in place and will soon be able to dress himself)

| **Health need** | **How does this need affect the child or young person's access to learning?** | **What provision will be provided to meet this need?** | **Who will deliver it?** | **How often and for how long?** | **Does the person delivering the provision require any training? If so, where will this be accessed?** | **How often will the provision be reviewed and by whom?** | **What is the aim of your provision in the short term?** | **What is the aim of your provision in the long term?** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Child A has a diagnosis of epilepsy and can have absence seizures frequently throughout the day* | *Child A can become tired after the seizures and find it harder to concentrate in school and retain information.* | *We will review Child A in our epilepsy clinic alongside the Consultant Neurologist and adjust medication where required.* | *Specialist epilepsy nurse* | *Every 6 months for 1 hour* | *N/A*  *e.g, school staff will be trained in emergency epilepsy medication by the epilepsy nurse* | *Every 6 months by the Epilepsy Nurse* | *To reduce and stabilise Child A’s seizures so they become less frequent.* | *To continue to monitor and control Child A’s seizures to ensure he is able to continue to attend school and achieve his educational goals.* |
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**If provision required is not within your core commissioned service, has a referral been made to the children and young people’s service (**[**nwicb.send@nhs.net**](mailto:nwicb.send@nhs.net)**) to progress with the responsible NHS ICB?**

Yes  No

If yes, please state the date it was made: Click or tap to enter a date.

**Are any further actions required?**

**Has the children and young people’s service been contacted at the ICB to consider individual funding?**

Yes  No

If yes, please state the date it was made: Click or tap to enter a date.

**Please attach any relevant reports and clinic letters from the last 12 months and submit with your advice.**

**Should an EHCP be produced it will be reviewed annually or sooner if required.**

**Name of practitioner:** Click or tap here to enter text.

**Job title/designation:** Click or tap here to enter text.

**Organisation:** Click or tap here to enter text.

**Signature of practitioner:**



**Date:** Click or tap to enter a date.