



# HOSPITAL TEACHING REFERRAL

*To be completed by staff from hospital in which SSEN:MMH do not have a permanent presence.*

Student Name:		Date of Birth:
School:		Year:
Name of Parent/Guardian:		
Contact Phone Numbers:	Home:	Mobile:
Address:		

Signed School of Special Educational Needs: Medical and Mental Health Consent Release and Exchange of Information provided

Y N

Conditions of Hospital Teaching Service discussed with parent?

Y N

Hospital/Health Professional Name	
Contact Phone:	Email:
Address:	
Special Considerations:	
Signature:	Date: