School of Special Educational Needs
Medical & Mental Health

MEDICAL REFERRAL

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

SSEN:MMH Consent for Information Exchange received? ☐

Conditions of Medical Referral discussed with parent? ☐

Availability of adult supervisor in home:		**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**
	am					
	pm					

Medical Certificate attached/provided:	**Y** ☐ ☐ **N** **Length of absence from school specified in Certificate:**	
Hospital/Health Professional Name & Contact details:		
Special Considerations:		
Length of absence from school prior to this referral:		
General history of school attendance:		
Contact Teacher's Name:		
Contact Teacher's Details:	**Phone:**	**Email:**

(We aim to keep communication with school through a nominated contact teacher, however sometimes contact with subject teachers may be necessary.)

PRIORITY SUBJECTS **(in order of preference, maximum four)**	**TEACHER'S NAME**	**CONTACT INFORMATION** **Email / Telephone**

Referrer's name: **Position:**

Signature: **Date:**

Contact Email: **Contact phone:**