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:		
Email:		

SSEN:MMH Consent for Information Exchange attached ☐
Medical Referral discussed with parent ☐

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

Medical Certificate attached/provided: (*A medical certificate from the treating health team / professional is required)	**Y** ☐ ☐ **N** (*Medical Referral cannot progress)
Length of absence from school as specified in Medical Certificate:	From _____ to _____
Hospital/Health Professional Name & Contact details:	
Special Considerations:	
Length of absence from school prior to referral:	
General history of school attendance:	
Contact Teacher's Name:	
Contact Teacher's Phone:	
Contact Teacher's 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**

Enrolled School Contact	
Name:	Position:
Contact email:	Signature:
Contact Phone number:	Date: