



The Inclusive Kitchen

Referral Form

NAME	
DATE OF BIRTH	
LA/Support worker; Contact name	
LA/ Support worker; key contact role	
LA/ Support worker; key contact telephone	
Contact email	
SEND	NO KNOWN SEND Diagnosis SEND Support EHCP in application EHCP in draft EHCP in place
If the person has an EHCP, have the relevant sections/targets been attached to this referral?	YES NO N/A
Does the person have an Individual Learning Plan (ILP)?	YES NO N/A
Is the ILP attached to this referral?	YES NO N/A
Has the person undergone a risk assessment?	YES NO N/A
Is a copy of the risk assessment attached to this referral?	YES NO N/A
Does the pupil have an Individual Healthcare Plan?	YES NO N/A
If the pupil has an Individual Healthcare Plan, is it attached to this referral?	YES NO N/A
What is the focus for this individual?	



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PUPIL NAME	
Are there any other agencies involved, please list here	
If the pupil has a Behaviour Support plan, is it attached to this referral?	YES NO N/A
Days / Timing (1 session 2 hours (NO MORE THAN 2 FULL DAYS OR 4 SESSIONS))	
Preferred attendance duration	<i>E.g., one term</i>
Proposed start date	
Proposed end date	
Does the person attend any other Alternative Provision or have any other support?	YES NO N/A If yes please give details
If Yes, please specify days and times	
If Yes, which course(s) (provide level)	
Where does the funding for this placement come from?	
Any other information.	