



INFORMATION PASSPORT

Please return form to:
Linda.Thompson@trafford.gov.uk

The following information is required in addition to the completed information passport:
Where possible it is preferable that all documents are sent electronically.

In all cases:

Reviewed and current IEP	Attendance information
Most recent progress report (and explanation of measures of progress used if not using levels)	Current timetable
Early Help Assessment (and subsequent action plans and reviews)	
Behaviour Management Plan / Risk Assessment or use Appendix 3	
Please tick if parents / carers have given their permission for the referral information to be shared	

Where applicable:

EHCP (final / application) / Statement of Special Educational Needs

SECTION 1: About you (the referrer)

Name:

Representing School:

Telephone Number:

E-mail address:

SECTION 2: About the young person

Name:

DOB:

Year:

Gender:

UPN:

UCN:

UCI:

Contact Details:

Primary

Emergency

Contact Name

Relationship

House Name

House Number

Street	<input type="text"/>	<input type="text"/>
Town	<input type="text"/>	<input type="text"/>
County	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>
Telephone Number	<input type="text"/>	<input type="text"/>
Mobile Number	<input type="text"/>	<input type="text"/>
E-mail Address	<input type="text"/>	<input type="text"/>
Is this child looked after?	<input type="text"/>	Is this child adopted? <input type="text"/>
Is this pupil on the Child Protection Register?	<input type="text"/>	Is the student entitled to FSM? <input type="text"/>
Is the student disabled?	<input type="text"/>	<i>Please provide details</i> <input type="text"/>
Ethnicity:	<input type="text"/>	Language: <input type="text"/>
		Religion: <input type="text"/>

Reason for referral:

Enter text here

SECTION 3: Special Educational Needs

SEN Status:

Date of last review:

Are you aware of any additional needs in any of the following areas?

<i>Area of need</i>	<i>Additional information i.e. treatment /aids required</i>
Hearing	<input type="text"/>
Vision	<input type="text"/>
Speech and Language	<input type="text"/>
Autistic Spectrum Conditions	<input type="text"/>
Attention Deficit Hyperactivity Disorder	<input type="text"/>
Other <input type="text"/>	

Please indicate the support agencies who are involved with the young person (past & present).

<i>Past</i>	<i>Present</i>	<i>Agency</i>	<i>Contact Name</i>	<i>Contact Number</i>
		CAMHS	<input type="text"/>	<input type="text"/>
		Youth Offending Team	<input type="text"/>	<input type="text"/>
		Children's Services	<input type="text"/>	<input type="text"/>
		Social Care	<input type="text"/>	<input type="text"/>
		Prevent & Deter	<input type="text"/>	<input type="text"/>
		Police	<input type="text"/>	<input type="text"/>
		Other <input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION 5:

What is the cause of the issue(s)?

Enter text here

What is the impact of the issue(s)?

Enter text here

What strategies have been used to address this so far and, what are the outcomes? *(Please give timescales)*

Enter text here

What outcomes would you like for the young person and how can the service support you in achieving this?

Enter text here

Does the young person present a risk to themselves or others?

Enter text here

Strengths and Difficulties Questionnaire

Professional to complete

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best as you can even if you are not absolutely certain or the item itself seems daft! Please give your answers on the basis of the child's behaviour over the last 6 months.

Child's Name:

	Not True	Somewhat True	Certainly True
<i>Please use 'Y'</i>	Y	Y	Y
Considerate of others people's feelings/			
Restless, overactive, cannot stay still for long/			
Often complains of headaches, stomach aches or sickness.			
Shares readily with other children (treats, toys, pencils etc).			
Rather solitary; tends to play alone/			
Generally obedient; usually does what adult requests.			
Many worries, often seems worried.			
Helpful if someone is hurt, upset or feeling ill.			
Constantly fidgeting or squirming.			
Has at least one good friend.			
Often fights with other children or bullies them.			
Often unhappy, down-hearted or tearful.			
Generally liked by other children.			
Easily distracted, concentration wanders.			
Nervous or clingy in new situations, easily loses confidence.			
Kind to younger children.			
Often lies or cheats.			
Picked on me or bullied by other children.			
Often volunteers to help others (parents, teachers, and children).			
Thinks things out before acting.			
Steals from home, school or elsewhere.			
Gets on better with adults than with other young people.			
Many fears easily scared.			
Sees tasks through to the end. Good attention span.			

Name of person completing form:

Today's date:



Thank



Trafford Alternative Education Provision

Name		D.O.B:	
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Risk	High	Medium	Low	How to manage the risk
Violence to adults				
Aggression to peers				
Possession/use of offensive weapon				
Association with gangs				
Bullying				
Substance abuse				
Danger of self-harm				
Impulsive behaviour				
Sexualised behaviour				
Anti-social behaviour				
Arson/vandalism				
Theft				
Parental issues				
Offsite visits				

Additional Information:

Completed by		Date	
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