

**Send to:** [**bht.cyptehcp@nhs.net**](mailto:bht.cyptehcp@nhs.net)

**Buckinghamshire Children and Young People’s Therapies**

**Request to Assess to Inform an Annual Review**

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| **Which service/s are you referring to:** | |
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| Occupational Therapy Physiotherapy Speech and Language Therapy | |
| To request CYP Therapies advice at an Annual Review when therapies provision is not currently on the  EHCP and new or changed needs have been identified.  Please send this form to CYP Therapies at: [bht.cyptehcp@nhs.net](mailto:bht.cyptehcp@nhs.net) with the subject line stating ‘Request to Assess to Inform Annual Review’ 8 weeks prior to the Annual Review date. | |
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| **Child/Young Person’s Information:** | |
| First Name: | Family Name: |
| Date of Birth: | NHS Number: |
| Male **•** | Telephone Number  Email |
| Home Address: | |
| Parent/guardian name and preferred contact details: | |
| \*Language(s) spoken at home  \*Ethnic Origin *(if known)* | \*Interpreter required for parent No/Yes  \*Interpreter required for student No /Yes |

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| **Student’s School/Setting** | |
| School/ Setting: | Year/Level: |
| Date of most recent EHCP plan *(please attach):* | |

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| **Date of Upcoming Annual Review:** |
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| **Child’s current diagnoses (please attached relevant evidence):** |
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| **Please outline new therapy needs which have been identified:** |
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| **Please outline the strategies and support available through Ordinarily Available Provision you have put in place to support the identified therapy needs, and what contact or support you have had from our service:** |
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| **Please provide evidence on how this support has impacted on the CYP’s progress within Assess, Plan, Do, Review cycles e.g. termly reviews (please outline or attach):** |
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| **Please describe the short/long term SMART outcomes for this child:** |
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| **What do you hope to achieve from this request?:** |
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| **Which other services are involved?:** |  |  |  |
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| **Do you have permission from the parent/guardian to make this request?:** |
| Parental signature or verbal consent: |

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