

Alternative Provision Service

PACE KS1&2 PRU
St Helens PACE
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REFERRAL OF KS1/2 PUPIL TO PACE PRIMARY PUPIL REFERRAL UNIT

PUPIL'S DETAILS

Name: _____ Date of Birth: _____ Name of Parent/Carer: _____

Address: _____ Year Group _____ Tel No: _____

Postcode: _____ Gender: _____ Emergency Contact:
Name: _____
Relationship: _____
Tel No: _____

Siblings and position in family 1 2 3 4 5 6 7
MF MF MF MF MF MF MF
(tick for subject and circle as appropriate for others)

Any relevant information concerning family circumstances:

ACADEMIC DATA

Is the pupil at Age Related Expectation? Y/N

| | Working at Y1-6? | Emerging/Expected/Exceeding? |
|----------------|-------------------------|-------------------------------------|
| Reading | | |
| Writing | | |
| Maths | | |

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REFERRAL DETAILS

School:

Name of Referrer:

Address:

Date of Admission to School:

Postcode:

Email:

Class Teacher and email address (this is so class teacher from PACE can liaise on strategies etc):

Previous schools with dates:

- 1.
- 2.
- 3.

Is the pupil looked after by the Local Authority Y/N

If yes, is it a voluntary agreement or Care Order?

Is the pupil entitled to free school meals? Y/N

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LAUNCHPAD



ETHNICITY (tick appropriate box)

| | | |
|----------------------------|------------------------------|-----------------------------------|
| White British | White Irish | White Traveller of Irish Heritage |
| White Other | Gypsy/Roma | White and Black Caribbean |
| Indian | Pakistani | Bangladeshi |
| Any Other Asian Background | Caribbean | African |
| Any Other Black Background | Chinese | Any Other Ethnic Group |
| Refused | Information Not Yet Obtained | |

MEDICAL INFORMATION

Does the pupil have any of the following medical conditions? (please circle)

Hearing Impairment Eczema/Dermatitis Diabetes Rheumatism Vertigo
 Colour Blind Heart Condition Epilepsy Asthma Allergy
 Poor Eyesight Physical Disability

Other conditions (please give details)

ATTENDANCE

| | |
|--|--------------|
| % last year | % as present |
| If attendance is below 80%, are the EWS involved Y/N | |
| Name of EWO: | |

EXCLUSIONS

Number of Fixed Term Exclusions in the last 12 months

| Date | No. of Days | Reason |
|------|-------------|--------|
| | | |

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FURTHER INFORMATION

Is the child in receipt of a provision agreement? Y/N

Is there an EHCP assessment in place? Y/N Who is the case work manager?

Is there an EHCP in process?

Brief description of identified needs and what additional support is given in school to meet the pupil's needs?

NATURE OF MAIN CONCERNS (please tick as appropriate).

| | | | | | |
|-----------------------|--------------------------|---------------|--------------------------|----------------------------|--------------------------|
| Anti-Social Behaviour | <input type="checkbox"/> | Refusal | <input type="checkbox"/> | Relationship with Adults | <input type="checkbox"/> |
| Withdrawal | <input type="checkbox"/> | Work Skills | <input type="checkbox"/> | Relationship with Teachers | <input type="checkbox"/> |
| Family Issues | <input type="checkbox"/> | Being Bullied | <input type="checkbox"/> | Off-Task Behaviour | <input type="checkbox"/> |
| Aggression | <input type="checkbox"/> | Phobias | <input type="checkbox"/> | Classroom Behaviour | <input type="checkbox"/> |
| Defiance | <input type="checkbox"/> | Bullying | <input type="checkbox"/> | Truancy/Exclusion Risk | <input type="checkbox"/> |
| Emotional Concerns | <input type="checkbox"/> | Social Skills | <input type="checkbox"/> | Developmental Delay | <input type="checkbox"/> |

OTHER AGENCIES INVOLVED

| Agency/Service | Tick | Ongoing? | Key Worker | Contact Number |
|-----------------------------|--------------------------|----------|------------|----------------|
| Education Psychologist | <input type="checkbox"/> | Y/N | | |
| Behaviour Improvement Team | <input type="checkbox"/> | Y/N | | |
| Education Welfare Service | <input type="checkbox"/> | Y/N | | |
| Youth Offending Team | <input type="checkbox"/> | Y/N | | |
| Police | <input type="checkbox"/> | Y/N | | |
| Social Care | <input type="checkbox"/> | Y/N | | |
| School Nurse | <input type="checkbox"/> | Y/N | | |
| CAMHS | <input type="checkbox"/> | Y/N | | |
| Classroom Assistant/Support | <input type="checkbox"/> | Y/N | | |
| Other: | <input type="checkbox"/> | Y/N | | |

Parental Consent

We (the pupil's school) have discussed the referral with the pupil's parents/carers.

Signature of parents/carers Date

This referral has/has not been discussed with the pupil.

Signature by School's Representative

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Checklist

Please attach the following if applicable:-

- Pupil's Timetable
- IEP/IBP (at least two most recent documents)
- Educational Psychologist's Report
- EHCP
- Boxall profile

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