

Additional Support for Learning (ASL) Form 10a

Request for Assistance: Specialist Nurse for Children with Complex Health Needs / Moving and Handling

Guidance for completing this form

This form is to request the assistance of the Specialist Nurse for Children with Complex Health Needs (SN CCHN) and/ or request Moving and Handling training.

SN CCHN will use this information to assess the need for a School Health Care Plan

Moving and Handling co-ordinator will use this information to assess the request and plan next steps.












If any of the information requested is not relevant to the child or young person, please just indicate with N/A

Section A Consent	Parental consent needs to be obtained for the SN CCHN and the Moving and Handling co-ordinator to engage and share information. Please tick the box to confirm you have gained this consent and give the date this was done. It is always advisable to have written consent for your records.
Section B Details	Child/young person's height and weight is only required for Manual Handling training requests. Manual Handling training team require this information to plan the support for staff who are handling the child/ young person
Section C Documentation	Please indicate if the child or young person has the documentation named in this section. This information is very helpful in processing this request. If the child/ young person has any of these supporting documents please send with this request.
Section D Professionals	This section is particularly important for the request for a School Health Care Plan. Please list all the relevant professionals that are involved with the child. If the contact details for these professionals are included in any of the supporting documentation e.g. Assessment of Need and Child's Plan, there is no need to duplicate the information. Please check the box to indicate the information is within these plans. If you require more space please note the information in the accompanying email.
Section E: Medical Condition	In this section please give a brief overview of the child/young person's medical condition and/or moving and handling needs that you are aware of. If you require more space please note in accompanying email.
Section F: Referral details	Please complete your information - this is a required field

When completed please send this form and any supporting documentation **ASLS.healthcare@ea.edin.sch.uk** with the email subject **Form 10a**. Please also copy in your establishment **ASL Service Leader**.

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Section A: Parental Consent			
I have gained parental permission to engage the Sn CCHN & Moving and Handling co-ordinator. I confirm that parents also give their consent to the sharing of related information between education and health professionals.			
Date Parental Permission attained			
Section B: Child /Young Person's Details and Information			
Child/Young Person's Name			
Date of Birth			
Height and Weight			
Home Address			
Parents/Carers Name			
Parent/Carer Contact Number(s)			
Parent/Carer email			
Home Language		<input type="checkbox"/>	Interpreter required
Current Placement/Establishment			
Reason for request (brief outline)			
Section C: Child /Young Person's Supporting Documentation			
Please check the boxes below to indicate if the child/young person has			
<input type="checkbox"/>	Assessment of Need & Child's Plan		
<input type="checkbox"/>	Existing Healthcare Plan		
<input type="checkbox"/>	Existing Moving and Handling Plan		
If possible please include copies of these forms with this request			
Section D: Professional Contacts			
Please could you give the names and contacts of all professionals involved, if this information is contained in accompanying documents there is no need to duplicate this information. Please tick the box to indicate			
Professional	Name	Contact Details	
Please select		<input type="checkbox"/>	 @
Please select		<input type="checkbox"/>	 @
Please select		<input type="checkbox"/>	 @
Please select		<input type="checkbox"/>	 @
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Please select		<input type="checkbox"/>	 @

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Section E: Medical Conditions and Mobility	
Please give details of the nature of your request below	
Details of Medical Condition (e.g. name of condition (if known) and symptoms)	
Details of Care Required (e.g. personal care, medication, blood tests, chest physio, with as much detail as possible)	
Details of degree of mobility, any mobility equipment used/likelihood of falls (e.g. Independent or requires assistance with mobility, uses a wheelchair, walking frame)	
Details of Equipment Currently Used: (e.g. hoist type, sling model / size, chair(s), standing frame, walking frame, commode)	
Details of handling anticipated or required to be carried out within the school environment (e.g. chair to bench, sit to standing frame, no. of staff required)	
Details of Emergency Medical Care (e.g. emergency epilepsy medication, gastrostomy falls out, when to call 999)	

Details of any Medication required to be taken during the school day		
Medication	Dose	Comment

Section F: Referrer Contact Details	
Please complete relevant sections below	
Completed by:	
Designation:	
Contact Details:	
Date:	

Please return completed forms and additional documentation to ASLS.healthcare@ea.edin.sch.uk