AUTISM SUPPORT TEAM
REQUEST FOR SUPPORT

SCHOOL DETAILS

School name:	Date:
Name of person making request:	Signature:
Email:	Telephone No:

PUPIL DETAILS

Name of Pupil:	Date of Birth:	Year group:
Gender:	Unique pupil number:	
Is the pupil looked after? Yes/No	EHCP Yes/No	Is this request to support an application/transfer to EHCP Yes/No
Date diagnosed:	Name of diagnosing doctor:	
Any other known conditions:		
What are the pupil's strengths?		
Describe the specific behaviours/difficulties that have led to this referral		
What level of support are they currently receiving?		

SUPPORT REQUIRED

Communication □	Visuals □	Classroom organisation □
Staff training □	TEACCH □	Challenging behaviour □
Other (please state)……..		

CONSENT

Name of parent/carer who has given consent:
How was parental consent obtained:
Date consent was obtained:
Name of member of staff who obtained consent:

The completed form should be sent to:

Jonathan England
Autism Support Team (Head)
Childrens and Adults Support Services
PO Box 64529
London SE1 5LX
Tel: 0207 525 3824. Email: jonathan.england@southwark.gov.uk