|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **EHCP Assessment Request**  **Consent Form** | | Date | |  | | |
| **Name of child/young person Date of birth** | | | | | | |
|  | | |  | | | |
| **Current Address** | | | | | | |
|  | | | | | | |
| **Contact number of parent/carer/young person Email contact** | | | | | | |
|  | | |  | | | |
| **When an Education Health Care Plan has been issued and all agencies are in place to support the plan, consider closing the Early Help if no wider needs are identified/ongoing** | | | | | | |
| **Request for EHCP assessment following review  *(Please include any meeting notes that demonstrate a multi-agency decision for this request)***  ***(Please note, as part of this assessment process you will be contacted by a social care team member and you may also be contacted by your local health team)***  **I agree to the gathering and sharing of information on this form with agencies who are or may become involved in the Education, Health and Social Care Statutory Assessment process.** | | | | | | |
|  |  | | | | | |
| **Consent given for EHCP assessment** | Yes  No | | | | **Date:** |  |

|  |  |
| --- | --- |
| **Parent/Carer Signature** |  |