|  |
| --- |
| **Child & Adolescent Mental**  **Health Service**  Oak Block  St. Ann’s Hospital  St. Ann’s Road  Tottenham  London N15 3TH  Telephone: 020 8702 3400/5154  Website: [www.behcamhs.nhs.uk](http://www.behcamhs.nhs.uk) |

**Health Advice Contributing to an Education, Health, and Care Needs Assessment**

Please note that this advice will be shared with children, young people, parents/carers, and other professionals involved with the child/young person. This advice must be typed.

|  |  |
| --- | --- |
| **Child/Young Person’s Name:** | |
| Setting: | **Date of Birth:** |
| National Curriculum Year: | **Female/Male** |
| **Name of Person Submitting Advice:** | |
| **Title of Person Submitting Advice**: | |

**Background Information:**

**Progress in therapy**

* **CYP Views:**
* **Description of the child/young person’s strengths and needs:**

|  |
| --- |
| **Assessment**  NB: Formal or informal ass  Observations in therapy or at school/home |
| **Summary of Strengths Needs and Impact:**  **Strengths**  Example: Strong interpersonal relationships with peers  **Needs**  Example: Inability to verbalise feelings |

**Desired Outcomes for the end of Key Stage [KS2]**

|  |
| --- |
|  |

**Provision Required to achieve outcomes above:**

|  |
| --- |
| **Strategies and School Interventions** |
| **Health/CAMHS/TAVI Provision** |

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete opinions on the matters to which they refer.

**Signed:**

**Title: Date:**

**Checked by:**