Please return to:
Debbie Lee
Education Liaison Service
Young Epilepsy,
St Piers Lane, Lingfield, Surrey RH7 6PW
Telephone: 01342 832243
Extn 577
education@youngepilepsy.org.uk

APPLICATION FOR PLACEMENT

We should be grateful for your assistance in completing this form as fully as possible as the information will be circulated to members of the multidisciplinary team to assist in our assessment procedure. Thank you.

APPLICANT		
FULL NAME:		**DATE OF BIRTH:**
ADDRESS:		
NATIONALITY	**RELIGION:**	**HOME LANGUAGE:**
NHS NUMBER:		**MALE / FEMALE**
PLACEMENT COMMENCING SEPTEMBER: 2017* / 2018* / 2019*/ 2020* **(*PLEASE CIRCLE)**		
PLACEMENT: DAY* WEEKLY BOARDING* /RESIDENTIAL TERMLY 38wks*/ 48wks*/ 52wks (*PLEASE CIRCLE)		

LOCAL AUTHORITY CONTACT	
Name	
Address	
Telephone Number	
E-mail address	

LEARNER'S CURRENT SCHOOL / COLLEGE		
Name	**Address**	**Telephone Number**

LEARNER'S DIAGNOSIS	
1	
2	
3	
4	

PLEASE PROVIDE AS MUCH OF THE FOLLOWING DOCUMENTATION AS IS APPLICABLE		
DOCUMENT REQUIRED	**YES/NO**	**TICK IF ATTACHED**
• Statement of Special Educational Needs		
• School Report		
• Annual Review		
• Respite Report		
• Behaviour Plan		
• EHCP/S139A moving on plan / transition plan		
• Medical Reports / Letters/clinic notes		
• Physiotherapy Reports		
• Occupational Therapy Reports		
• Psychologist's Reports		
• Speech and Language Reports		
• Psychiatrist's Reports		
• DOLS Approval		
• Deputyship Data		

ETHNIC ORIGIN Please tick relevant box below					
WHITE British ☐ Irish ☐ Other White background ☐	**MIXED** White / Black Caribbean ☐ White / Black African ☐ White / Asian ☐ Other mixed background ☐	**ASIAN OR ASIAN BRITISH** Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian background ☐	**BLACK OR BLACK BRITISH** Caribbean ☐ African ☐ Other Black background ☐	**CHINESE** ☐	**ANY OTHER ETHNIC BACK-GROUND** ☐

Parental Responsibility: In accordance with The Children Act 1989, please give full details below of ALL persons who have parental responsibility and to whom correspondence, reports, invitations etc. should be sent.

NAME: please include titles Mr, Mrs, Miss, Ms	RELATIONSHIP TO APPLICANT	OTHER DETAILS
		Home no: Work no: Mobile no: E-mail: **ADDRESS IF DIFFERENT TO APPLICANT:**
		Home no. Work no: Mobile no: E-mail: **ADDRESS IF DIFFERENT TO APPLICANT:**

NAME(S) OF SIBLING(S)	DATES OF BIRTH

APPOINTED DEPUTIES

Are you an appointed deputy for your son/daughter?

YES ☐ NO ☐

EDUCATION

CURRENT/LAST SCHOOL/COLLEGE	Type of establishment	Dates attended	
Name		**From:**	**To:**
Address **Postcode** **Telephone**	**Local Education Authority** **Telephone** **Contact Name**		**Class Size**
Details of Qualifications applicant working towards			**Date of expected date of completion**

LEISURE/HOBBIES/CLUBS

RELIGIOUS OR CULTURAL NEEDS e.g. diet, clothing or worship

MEDICAL INFORMATION

EPILEPSY	Yes	No	Details
Does the applicant have seizures?			
Date when seizures first started			
If yes, please detail seizure types Frequency eg. Daily/weekly, monthly	1. 2. 3. 4. 5.		
Do seizures ever occur in clusters?			
Is extra medication required to stop a cluster of seizures?			
Has a seizure ever lasted longer than 30 minutes? If yes, has this require admission to ITU?			
Has the applicant ever had non-convulsive status epilepticus (NCSE)			
Has the applicant ever required hospital admission in relation to their epilepsy? If so, where and when?			
Is an emergency protocol/rescue medication regime in place? Please give details.			
Does the applicant have any warning before a seizure.			
Does the applicant ever injure themselves during a seizure?			
Are there any identifiable seizure triggers?			
Are there any behaviour/mood changes before/after a seizure?			

MEDICATION **Please ensure that all current medication is listed and any changes are notified in writing.** *An adequate supply of in date medication (including any emergency medication) must be provided for the two day assessment, as dispensed by the pharmacy. Please hand this to staff on arrival*

Routine Drug/s (Name)	Strength/s	Dosage/s	When and how administered

Emergency Drug/s (Name)	Strength/s	Dosage/s	When and how administered

Does the applicant suffer or require treatment for any of the following conditions?

	Yes	No	Details
Diabetes **Type 1** **Type 2** **Other**			
Asthma			
Eczema			
Heart Problems			
Any Allergies **Drugs** **Food**			
Any other disability/ medical condition			

	Yes	Not now but in past	No
Are there any eyesight problems? **Do they wear glasses**			
Are there any hearing problems? **Do they have aids**			
Please detail any treatment for these			

DIETARY REQUIREMENTS Please give details of any special dietary food requirements or food allergies

SPEECH AND LANGUAGE THERAPY (SLT)

COMMUNICATION

How would you describe your son/daughter's ability to communicate with people?

What do you see as his/her strong points in communicating?

Please describe any concerns you have or areas that you feel still need developing

Has your son/daughter ever used sign language/symbols/objects of reference/PECS/electronic communication aid/communication book?

SLT INPUT

If your son/daughter sees a SLT at their current school, do you have contact with the therapist?

Do you know what they do?

Do you feel your son/daughter needs SLT input at Young Epilepsy?

If so, what areas would you want us to work on?

ORAL SKILLS/HEARING

Does s/he experience any chewing, swallowing, dribbling or choking problems? Please describe any concerns

Has s/he ever needed tube feeding?

Does s/he experience any hearing problems? Please describe any concerns

When was the last known hearing test and what was the result?

Has your son/daughter attended ENT or Audiology at any hospital? Please say where and when

OCCUPATIONAL THERAPY

Has your son/daughter had any OT input at school or at home?

Do you know what this was for? (e.g. equipment, fine motor skills)

Do you feel your son/daughter needs OT input at Young Epilepsy?

If so, what areas would you want us to work on?

Does your son/daughter experience any visual difficulties? Please describe any concerns?

Has your son/daughter attended any Opthalmology or Orthoptic appointments at any hospital? Please say where and when

SELF CARE	Please give details of help needed and equipment used
Dressing	
Eating/Drinking	
Toileting	
Shower/Bath	
Grooming e.g. hair care, nail care, teeth cleaning	
Shaving / hair removal	
Menstruation	
TRANSFERS	**Can your son or daughter get on/off or in/out of the following? Please give details**
Bed	
Chair	
Toilet	
Floor	
Bath	

MANUAL DEXTERITY	Can your son or daughter do the following?
Buttons	
Zips	
Shoe laces	
Cut with scissors	
Write their name	
Apply make-up	
Put on own jewellery or watch	
Use a mobile phone	
Use a computer or game console e.g. Play station.	
PHYSIOTHERAPY	
ENVIRONMENTAL MOBILITY	Please indicate if your son or daughter can use the following and give details of help needed
Steps	
Stairs	
Lifts	
Escalators	
Public Transport	
Level of road safety awareness	
WALKING ABILITY	Please describe and give details of help needed
Speed of walking	(slow, average, fast etc)
Ability to run	
Walking stamina	(distance, fatigue, motivation etc)
Ability on slopes or uneven ground	

PHYSICAL ACTIVITIES	Please list any physical activities regularly practised by your son/daughter

ORTHOPAEDIC SURGERY / MONITORING	Has your son/daughter had any orthopaedic surgery or monitoring? Please describe with date

POSTURE
Do you have any concerns about your son/daughter's posture?

PHYSIOTHERAPY INPUT
Has your son/daughter had physiotherapy in the past? Are there any physiotherapy type concerns or issues which could help us?

EQUIPMENT

	Please give details of equipment your son/daughter would bring with them to Young Epilepsy
Wheelchair	
Wheelchair accessories	
Special seating	
Seating accessories	
Special footwear	
Orthotics (insoles, splints etc)	
Head protection	
Protective clothing	
Padding	
Bed (high-low, mattress, bed guard)	
Hoist or changing bed	
Hand splints	
Food preparation equipment	
Electronic voice communication aid	
Communication book or cards	
Other	

EQUIPMENT AT HOME **Please list any equipment at home that will not come with your son/daughter to Young Epilepsy**

EQUIPMENT NEEDED	**Please list any equipment that has been recommended or that you feel he or she may need but has not been supplied**
Equipment type	**Recommended by?**
Equipment type	**Recommended by?**
Equipment type	**Recommended by?**

PSYCHOLOGY

Understanding his/her diagnosis:

Note: Please provide us with any formal reports that support the information provided by you in this application form

Has your son/daughter been diagnosed with Autism Spectrum Disorders/Asperger's Disorder?

Yes □ No □ If yes, please specify when and by whom?

Has your son/daughter been diagnosed with Attention Deficit and Hyperactive Disorder?

Yes □ No □ If yes, please specify when and by whom?

Has your son/daughter been diagnosed with Learning Disabilities/Intellectual Disabilities?

Yes □ No □ If yes, please specify when and by whom?

What would you describe as his/her main difficulties (e.g. memory, concentration, attention, etc)?

Does your son/daughter present with emotional difficulties?

Yes □ No □ If yes, please specify

Has your son/daughter been diagnosed with a mental health condition?

Yes □ No □ If yes, please specify when he/she has been diagnosed and by whom using the table below.

If your son or daughter has been prescribed medication for behaviour or psychiatric issues, please provide us with the name of the drug and the dosage he or she has been prescribed.

Mental Disorders	YES	NO	When?	By Whom?
Anxiety Disorder				
Depressive Disorder				
Schizophrenia				
Bipolar Disorder				
Communications Disorders				
Rett's Disorder				
Tourette's Disorder				
Encopresis				
Enuresis				
Selective Mutism				
Other (please specify):				

Understanding his/her behaviour:

Behaviour **Does your son/daughter present with any of the following behaviours:**	**Yes**	**No**	**Specify (e.g. explaining incidents, circumstances, people involved, consequences etc)**
Physical aggression towards others *(e.g., hits, kicks, bites, etc)* or to property *(e.g. throws or breaks furniture)*?			
Antisocial behaviour - bullying *e.g. taunts, teases or bullies others*			
Lack social awareness *(e.g. acts over familiarly with strangers)*			
Overactive or restless.			
Verbal aggression			
Absconding (running away).			
Sexually inappropriate behaviour (e.g., exposes self, masturbates in public, makes improper sexual advances).			
Self-injury (*e.g., bangs head, hits and bites self, picks skin, etc)*			

Behaviour (continued) Does your son/daughter present with any of the following behaviours:	Yes	No	Specify (e.g. explaining incidents, circumstances, people involved, consequences etc)
Anger outbursts			
Non-compliant / uncooperative.			
Other (please specify)			

Has your son/daughter ever been 'excluded' or 'sent home' from school/college or respite care because of behaviour?

If so, please specify the circumstances

Does your son/daughter need 1:1 support?

If so, please details

Previous/Current Psychological Input:

Is your son/daughter receiving individual therapy with a psychologist?
Yes □ No □ If yes, please specify the purpose of the intervention :

Has he/she received individual psychological input in the past?
Yes □ No □ If yes, please specify when and by whom and purpose of the intervention:

Is your son/daughter receiving group therapy with a psychologist?
Yes □ No □ If yes, please specify the purpose of the intervention :

Has he/she received group therapy in the past?
Yes □ No □ If yes, please specify when and by whom and purpose of the intervention:

Has your son/daughter received any input regarding his/her behaviour?
Yes □ No □ If yes, please specify the purpose of the intervention :

Have any behavioural programmes, guidelines or risks assessments being created?

Yes □ No □ If yes, please could you provided us a copy.

Is your son/daughter being regularly reviewed by a psychiatrist?
Yes □ No □ If yes, please specify the purpose of the intervention :

Has he/she received psychiatric input in the past?
Yes □ No □ If yes, please specify when and by whom and purpose of the intervention:

SLEEPING

Does the applicant:	Yes	No	Please give details
Sleep in a bed?			
Sleep soon after going to bed?			
Sleep through the night usually?			
Require intensive supervision at night?			

What time does the applicant go to bed?

What time does the applicant usually wake up?

Please give details of any bedtime/morning routines?

Please give details on any sleep disturbances

Please give details regarding any night time seizures

CONTINENCE

Does the applicant:	Yes	No	Please give details
Use toilet independently day and night?			
Have a catheter, colostomy or anything else needing specialist care?			
Indicate the need for the toilet?			
Sit on the toilet?			
Need incontinence pads during the day?			
Need incontinence pads at night?			
Need toileting at night?			

Please give any other details that may help with toileting

RESPITE SERVICES

Have Respite Services ever been involved with the applicant?

How often do they have Respite?

Name of Respite Services

Address

Postcode **Telephone**

Details of involvement

Please attach copies of any reports produced by Respite Services

SOCIAL SERVICES

Have Social Services ever been involved with the applicant?

Name of Social Worker

Address

Postcode **Telephone**

Details of involvement

Please attach copies of any reports produced by Social Services

EXPECTATIONS

Why is a placement at the Young Epilepsy required?

What are the expectations of the Young Epilepsy:
a) from the Parents/Carers:

b) from the Applicant:

Any other relevant information which may be helpful during the assessment period:

What other providers have you applied to?

SIGNATURES

Information on this form provided by:

Name(s)

Relationship to Student

Signature(s) **Date**

Young Epilepsy has a policy to adhere to the 1998 Data Protection Act. The information we are asking you for may be placed in a manual file, placed on a computer database and passed to other individuals both internally and externally who are involved with the student.
By signing/completing this form you are agreeing to the above statement. If you do not agree to any aspect of this please indicate below.

Expertise in special educational needs

Parental Consent for Reports

LEARNER'S NAME	
ADDRESS	
DATE OF BIRTH	
NHS NUMBER	
NATIONAL INSURANCE NUMBER	
UNIQUE LEARNER NUMBER	

Consultant	**Neurologist**
Name	Name
Address Postcode	Address Postcode
Tel no	Tel no
Psychiatrist	**GP**
Name	Name
Address Postcode	Address Postcode
Tel no	Tel no
Psychologist (including educational)	**Social Worker**
Name	Name
Address Postcode	Address Postcode
Tel no	Tel no

LEARNER'S NAME	

CAMHS	Therapist
Name	Name
Address Postcode	Address Postcode
Tel no	Tel no
Surgeon (Neurosurgeon, Orthopaedic, other)	**Respite Care**
Name	Name
Address Postcode	Address Postcode
Tel no	Tel no

Current or Most Recent Education Provider i.e. School/6th Form or College
Name
Address Postcode
Tel no

As we may need to seek information from the professionals involved with the care of your son/daughter we would be grateful if you and your son/daughter could confirm below that you give your permission for us to do so.

Signed ……Parent / Guardian

Name…….. Please print ……Date

Signed ……Learner

Where appropriate please ask the learner to sign this form, with assistance if necessary

Please return this form to Education Liaison Service, Young Epilepsy,
St Piers Lane, Lingfield, Surrey RH7 6PW