|  |  |  |  |
| --- | --- | --- | --- |
| **St. Elizabeth’s Centre Application & Initial Assessment Information** | | | |
| Name: |  | I like to be known as: |  | |
| Current Address: |  | Service/s Required:  (Please tick those that apply) | Supported Living  Day Services | |
|  | **College**  Education & Supported Living  Education Only | |
|  | **School**  Education & Children’s Home  Education Only | |
| DOB: |  | Requested Admission Date:  (Month & Year) |  | |
| Contact Number/s: |  | National Insurance Number: |  | |
| Ethnicity: |  | Nationality: |  | |
| NHS Number (*if known*): | | | | |
| **Are you subject to a Home Office deportation order?** Yes / No | | | | |
| **Are you able to provide proof of eligibility for funding purposes, for example passport?** Yes / No | | | | |

|  |  |
| --- | --- |
| Funding Authority (Social Services, CCG, private etc.): |  |
| Named Contact Person & Address: | |
| Telephone Number: | |
| E-mail Address: | |
| Name of SEN Representative:  (if different to the above) | |
| E-mail Address: | |
| Name of Connexions Advisor:  (if applicable) | |
| E-mail Address: | |
| **Is your Local Authority aware of this application?** Yes / No | |

|  |  |
| --- | --- |
| **Cultural / Spiritual Needs** | |
| I have a specific faith and/or belief | Yes / No / Prefer not to disclose |
| If yes, please state which faith group you belong to: |  |
| I like to attend services in relation to my faith / beliefs: | Yes / No |
| Please tell us what you may like to attend and how we can support with this: | |
| I have special days in the year that I wish to celebrate (please give details): | |
| My first language is English: | Yes / No |
| I speak or understand other languages: | Yes / No |
| If yes, please tell us the other languages you speak or understand: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Education** | | | |
| I have an Education, Health & Care Plan (EHCP): | | Yes / No | |
| If no, please provide details of the plan you currently have: | |  | |
| Current / Most Recent learning provider: | | | |
| Contact Number: | | | |
| E-mail Address: | | | |
| Please list the details of learning you have undertaken and any qualifications you are working towards or have achieved (if appropriate): | | | |
| Course | Level | Qualification | Date Completed |
|  |  |  |  |
| If you know, how best do you like to learn? | | | |
| Please provide details of the levels of support you normally have in class / during learning, if any: | | | |
| Please explain why you would like to attend St Elizabeth’s School / College. (Delete as appropriate) | | | |
| What are your hopes and aspirations for the future? | | | |

|  |  |  |
| --- | --- | --- |
| **Emotional Wellbeing** | | |
| Please use this section to describe your emotional wellbeing (do you have anxiety, depression, self-harm tendencies, vulnerability, shyness?) | | |
| Are you currently or have you ever been subject to any safeguarding investigations?  Yes / No | | |
| **Counselling** | | |
| If you have received any counselling or other professional psychological support, please provide us with any information relevant to your application if you wish to do so. | | |
| **Medical** | | |
| GP (General Practitioner) Name: |  | |
| Address: | Contact Number: |  |
| E-mail Address: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medical Diagnosis: | | | | | | |
| **Seizure Information (if applicable)** | | | | | | |
| Before a seizure I usually: | | | | | | |
|  | | | | | | |
| After a seizure I usually: | | | | | | |
|  | | | | | | |
| I have seizures at night: **Yes / No** | | | | | | |
| *(If YES please tell us about the frequency and type of seizures):* | | | | | | |
|  | | | | | | |
| Date of last EEG: |  | | Result: |  | | |
| Date of last MRI: |  | | Result: |  | | |
| Other information relevant to seizure management (*e.g. intervention medication, type of seizures and frequency):* | | | | | | |
|  | | | | | | |
| **Medication** | | | | | | |
| Drug Name | | Dosage | | | Time/s Given | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
| **Epilepsy Classification** *(tick all that apply)* | | | | | | |
| Active | | | | | |  |
| In remission (on medication) | | | | | |  |
| In remission (off medication) | | | | | |  |
| Single seizure | | | | | |  |
| Non-epileptic (associated disorder) | | | | | |  |
| Partial Epilepsy | | | | | |  |
| Generalised Epilepsy | | | | | |  |
| Primary generalised | | | | | |  |
| Secondary generalised | | | | | |  |
| Specific Syndrome | | | | | |  |
| Tonic / Clonic (includes tonic or clonic) | | | | | |  |
| Absences | | | | | |  |
| Myoclonic Jerks | | | | | |  |
| Drop Attacks | | | | | |  |
| Complex Partial Seizures | | | | | |  |
| Simple Partial Seizures | | | | | |  |

|  |
| --- |
| **Allergies / Drug Sensitivity e.g. foods, pollens, animals** |
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |

|  |  |
| --- | --- |
| **Mobility** | |
| I can walk independently: | **Yes / No** |
| I need help with: |  |
| I use these aids to help me: |  |
| When I go out, I need help with my mobility to (please specify help required e.g. in and out of vehicles, stairs etc.) |  |
| I have fallen in the last 12 months: | **Yes / No** |
| The reason/s I have fallen are: |  |
| Previous fractures: | **Yes / No** |
| If Yes, what was broken and when: |  |
| I have a history of Osteoporosis: | **Yes / No** |

|  |  |
| --- | --- |
| **Sensory Assessment** | |
| I have difficulties with my vision: | **Yes / No** |
| I wear glasses: | **Yes / No** |
| I have other visual difficulties (please specify): |  |

|  |  |
| --- | --- |
| **Hearing** |  |
| I have difficulty with my hearing: | **Yes / No** |
| I use hearing aid/s: | **Yes / No** |
| I have other difficulties with my hearing (please specify): |  |

|  |  |
| --- | --- |
| **Mental Health** | |
| I have experienced difficulties with my mental health: | **Yes / No** |
| I am under the care of a psychiatrist or psychologist: | **Yes / No** |
| At times I need help with behaviour management: | **Yes / No** |
| If yes to any of the above, please describe help required / input received: | |
| **Continence** | |
| I generally have normal bladder function: | **Yes / No** |
| I can usually control my bowel movements: | **Yes / No** |
| I wear pads *(please tick relevant box/es)*: | Only during the day  Only at night  Day and Night  Only when I go out |

|  |  |
| --- | --- |
| **Dietary Information** | |
| My current weight is: | **…………………….**kg |
| I have special dietary requirements: | **Yes / No** |
| If yes, please specify requirements: | |

|  |  |
| --- | --- |
| **Immunisations** | |
| Are all immunisations up to date?: | **Yes / No** |
| Date of last tetanus injection: |  |

|  |  |
| --- | --- |
| **Sleeping** | |
| Do you have difficulties settling at night: | **Yes / No** |
| If Yes, please tell us what the difficulties are and what helps them: | |
| Do you usually wake during the night: | **Yes / No** |
| If yes, please tell us as much as you can about what wakes you, how often and what we can do to help resettle you: | |
| **Therapy** | |
| I am currently receiving Physiotherapy: | **Yes / No** |
| If Yes, please tell us what they support you with and how often you access this service: | |
| I am currently receiving Occupational Therapy: | **Yes / No** |
| If yes, please tell us what they support you with and how often you access this service: | |
| I am currently receiving Speech and Language Therapy: | **Yes / No** |
| If yes, please tell us what they support you with and how often you access this service: | |
| Do you have any problems understanding others’ speech? | **Yes / No** |
| If yes, please provide details of what works to support you to understand: | |
| How do you express yourself? (Please tick those that apply) | Speech  Signing/ non-verbally  Communication Aids  Other |
| If other, please provide further details: | |
| **Additional Information** | |
| Please tell us about hobbies and interests you enjoy: | |
| Please use this space to tell us anything further you feel is relevant to your application: | |

|  |  |
| --- | --- |
| **Name and Address / contact details of person completing this form**  **(if different from front page)** |  |
| **Relation to applicant:** |  |

Date of form completion:

Thank you for the completion and return of this application. A member of the admissions team will be in contact with you in due course.