**Sunderland Virtual School**

**Tuition Service**

**Hospital Referral Form for Pupils with Medical Needs**

**For MEDICAL PROFESSIONAL STAFF only.**

**To be used when a pupil of statutory school age will be in hospital for more than 5 days and is able to access education. A copy of the form should be sent to the parents/carers and a copy retained by the Hospital.**

**Pupil Details**

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| --- | --- | --- |
| Pupil’s Name: | | Date of Birth: |
| Pupil’s Address: | | Home Tel No: |
| Parent/Carer Mobile Telephone Numbers: | | |
| School: | Local Education Authority: | |

|  |  |
| --- | --- |
| **Parent/Carer Details** | |
| Name of Adult with Parental Responsibility: | |
| Contact details if different to the above: | Tel No: |
| Is the pupil in the care of the LA? YES  NO | Local Authority: |
| Are the pupil’s parents/carers are aware of this referral? YES  NO  . |  |

**The pupil’s school will be contacted and asked for curriculum details, target and current grades and the loan of resources as part of the pupil’s Personal Education Plan, and the LA will be informed.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital Details** | | | |
| **City Hospitals Sunderland** | **Kayll Road, Sunderland** | Post Code: **SR4 7TP** | Tel No: 0191 5656256 |
| Consultant: | | Ward Manager: | |
| Duration of Hospital stay: | | Ward: | Wing: |
| **Medical Information:** | | | |
| Will the pupil require Home Tuition following the hospital stay? YES  NO  .  Approximate duration of recovery:  For pupils from other Local Authorities, this information will be provided to their school and LA. | | | |

Person making this referral:

Name:       Position:

Signature:       Date:

**Please return form via email to Shelley Robson at email:** [**VPP@togetherforchildren.org.uk**](mailto:VPP@togetherforchildren.org.uk)

**If further information is required contact Shelley on 07765 429145**