**SEND SUPPORT*ED***

 Dyslexia Assessment Referral Form

|  |  |
| --- | --- |
| Date of referral  |  |
| Name and email address of person making referral  |  |
| Learner’s name |  |
| Date of birth  |  |
| School |  |
| Reason for referral (please consider impact of support already in place, outcomes expected from the assessment following discussion between school, parents and learner). |  |

We can confirm that school, parents and the child / young person are all in agreement for this referral to be made.

Signatures

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (school representative)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/carer)

*(Referrals will not be accepted without both signatures).*