**Referral form to access support for Early Years Children with SEND- CONFIDENTIAL**

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| **Child’s Details** | | | | | |
| **Surname:** | | | **First Name/s:** | | |
| **Previously known as:** | | | **Gender: M / F** | | |
| **DOB:** | | | **Age in months:** | | |
| **Address and postcode:** | | | | | |
| **NHS Number (if known):** | | | | | |
| **Please select child’s Ethnicity:-**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **White:** | | **Mixed / multiple ethnic groups** | | **Asian / Asian British:** | | | British |  | White & Black Caribbean |  | Indian |  | | English |  | White & Black African |  | Pakistani |  | | Irish |  | White & Asian |  | Bangladeshi |  | | Gypsy or Irish Traveller |  | Any other mixed / multiple ethnic background (Please state): |  | Chinese |  | | Any other white background (Please state): |  | Any other Asian background (Please state): |  |  |  |  |  |  | | --- | --- | --- | --- | | **Black / African / Caribbean / Black British:** | | **Other ethnic groups:** | | | Caribbean |  | Arab |  | | African |  | Any other ethnic group | | | Any other Black / African / Caribbean background (Please state): | | (Please state): | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Other essential information** | | | | | | | Looked After Child (LAC) |  | Child In Need (CIN) |  | Child Protection Plan (CPP) |  | | Social Care |  | Early Help |  | Armed Forces |  | | Interpreter Required |  | Signer Required |  | Immigration Status: | |  |  |  | | --- | --- | | **Childs first language:** | **Parents first language:** | | | | | | |
| **Parent Names/s:** | | | | | |
| **Telephone number: Home Work** | | | | | |
| **Email address:** | | | | | |
| **Date of referral:** | | | | | |
| **HV referral** |  | **Portage referral** |  | **KIDS referral** |  |

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| **Referring Person Details & Setting Details** | |
| **Name of referrer:** | **Role of referrer:** |
| **Contact number and email:** | **Childs key worker:** |
| **Setting:** | **Child’s start date:** |
| **Setting address:** | |
| **Sessions and hours child is currently attending:** | |
| |  |  |  |  | | --- | --- | --- | --- | | **Day** | | **Hours** | | | Monday | |  | | | Tuesday | |  | | | Wednesday | |  | | | Thursday | |  | | | Friday | |  | | | **Total number of hours per week** | |  | | | **Term Time** |  | **Stretched offer** |  | | |
|  | |
| **Number of children per session/ per room:** | |
| **Number of children in room who receive inclusion support funding and level of funding:** | |

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| **Background Information** (please bullet point) |
| **Other agencies involved with names and contact details** |
| **Does the child have any diagnosis or currently undergoing assessments?** |

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| **Categories of need (please tick primary area of need)** | | | | | | | | |
| **Communication and interaction** | | |  | | **Cognition and learning** | | |  |
| **Social, emotional and mental health difficulties** | | |  | | **Sensory and/or physical needs** | | |  |
| **Stage of development in Prime Areas of EYFS** | | | | | | | | |
| **PSE- MR**  **SC/ SA MFB** |  | **C & L – L/A**  **U SP** | |  | | **PH- MH**  **H/ SC** |  | |
| **What are the child’s strengths / interests?** | | | | | | | | |
| **What are the child’s presenting difficulties?** | | | | | | | | |

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| **Breakdown of Graduated Approach (strategies tried and impact)** |
| **Current Targets & Level of Intervention**  1)  2)  3) |
| **What support do you think the child needs?** |

**This may be used as a notification to the Local Authority by Health**

Please ensure you have selected **YES** or **NO** for the statements below. Please cross out any services/ professionals the parents do not wish to share information with.

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| --- | --- |
| **I/we are happy for this document to be passed on to Educational Psychology if appropriate and I give permission for the setting to consult the Educational Psychologist.**  I have been informed of the purpose of this and I appreciate that the aim is to be helpful to my child. I understand that this may include some assessment and/or observation of my child by the Educational Psychologist who will inform me of outcomes. I agree that the Educational Psychologist can seek information from other professionals involved with my child, and share information with them (if appropriate) as well as work with my child. | **YES / NO** |
| **I/we are happy for information to be shared with other professionals and for any initial assessment/ observation to be carried out-**  Other professionals will include: Portage Service, KIDS, SALT, IPASS, ASD Panel, Tweendykes and Ganton (SLD) Outreach, Northcott (ASD) Outreach, Family Support, Health, The Language Unit. | **YES / NO** |

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| **Views and/or concerns of parent?** |

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| **Parental consent:** | **Date:** |
| **Referrers signature:** | **Date:** |

**Tick list for referral form**

Please see below documents required to support any referral to the Early Years Resource, Allocation and Support Panel.

Please tick to ensure you have included these documents

|  |  |
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| Complete referral form with parental signature |  |
|  |  |
| Early Intervention (at least 2 cycles) |  |
|  |  |
| Development Overview |  |
|  |  |
| Graduated Approach document |  |
|  |  |
| Assess, Plan, Do, Review |  |
|  |  |
| IHP / risk assessments (where appropriate) |  |
|  |  |
| My Passport |  |
|  |  |
| Observations (1 or 2 which highlight childs needs) |  |
|  |  |
| Information/ reports from other agencies |  |

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| Discussed with Area SENCO or Early Years Inclusion Support Officer |  |

**Failure to send the required documents may result in the referral been unsuccessful.**