**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:-**

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| --- | --- | --- |
| **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): |  |

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| **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): |

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| **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: |

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| **Childs first language:**  | **Parents first language:** |

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| **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:**  |
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| **Day** | **Hours** |
| Monday  |  |
| Tuesday |  |
| Wednesday |  |
| Thursday |  |
| Friday |  |
| **Total number of hours per week** |  |
| **Term Time** |  | **Stretched offer**  |  |

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| **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/ SAMFB** |  | **C & L – L/A****USP** |  | **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.**