**CHILDREN’S SERVICES**

**0 – 5 SEND Support Service**

**Building 7, Manor Lane Depot, Manor Way, Sheffield S2 1TR**

**0-5SEND.SupportService@sheffield.gov.uk** **(Password Protect)**

Tel No: 0114 2736411

 **REFERRAL FORM**

**This form must be fully completed if any child is to be referred to the 0 – 5 SEND Support Service. Please check that the information is accurate.**

**The Referrers signature box must be signed after permission has been granted by parent/carer.**

|  |
| --- |
| CHILD’S DETAILS |
| Family Name  |  |
| Forename |  | **Date of Birth** |  |
| Address |  | **Postcode** |  |
| **Tel Number** |  |
| Gender*please tick* | Female[ ]  | Male[ ]  | **Year Group*****please tick*** | -3[ ]  | -2[ ]  | -1/FS1[ ]  | 0/FS2[ ]  |

|  |
| --- |
| Name(s) of Parent(s) / Primary Carer(s) |
| Relationship to child |  |
| Forename |  | **Family Name** |  |
| Address |  | **Postcode:** |  |
| **Tel Number:** |  |
| Email:  |  |  |  |

|  |
| --- |
| Name(s) of other Carer(s) |
| Relationship to child |  |
| Forename |  | **Family Name** |  |
| Address |  | **Postcode:** |  |
| **Tel Number:** |  |

|  |
| --- |
| REFERRER INFORMATION |
| Name of Establishment Attended  |  |
| Type *(i.e. nursery, playgroup etc.)* |  |
| Entry Date at your Establishment |  |
| Looked after child | **Yes**[ ]  | **No**[ ]  |  |  |

|  |  |
| --- | --- |
| Name of Referrer |  |
| Job Title |  |
| Address |  | **Postcode** |  |
| **Tel Number** |  |
| Email Address |  |
| Date of Referral |  |

|  |
| --- |
| **THIS REFERRAL HAS BEEN FULLY DISCUSSED WITH THE PARENTS/CARERS OF THE CHILD** |
| **Signature of parent/carer** |  | **Date:** |
| **Signature of Referrer** |  |  |

|  |
| --- |
| Our Service depends on your consent to operate effectively. You will probably know that we regularly talk to other services - such as those providing social care services and health services about individual cases. That work cannot be done without disclosing personal information. You will be aware of these discussions in any event. What we need at this point is your agreement in principle to this approach. **I give my consent for the 0 -5 SEND Support Service to disclose to and receive from education, social care and health services personal information about my child as part of the services delivered.**  |
|  |
| **REASON FOR REFERRAL – PLEASE TICK ONE MAIN REASON FOR THE REFERRAL****(If child has other areas of need please detail in section 2)** |
|  |  |  |  |
| 🞏 | Physical / Medical Difficulties |  |  |
| 🞏 | General Learning Difficulties |  |  |
| 🞏 | Speech and Language / Communication Difficulties and SLCN is primary need**\***   |
|  | **\*** If the child has **NOT** been referred to Speech and Language, please state why; |
|  |  |
|  |  |
|  |  |
| 🞏 | Social Communication Difficulties |
|  |   |  |  |
| 🞏 | Social, Emotional and Mental Health Concerns |  |  |

**0 – 5 SEND SUPPORT SERVICE**

|  |
| --- |
| **ADDITIONAL INFORMATION** |
| 1. | Have you any concerns about the child’s hearing, vision or general health? |
|  | Yes | [ ]  | No | [ ]  |  |
|  |  |
|  | If yes, please give details |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |  |  |
| 2. | What are the main areas of concern regarding the child’s development? (Please comment on the child’s social interaction, speech, language, behaviour and play). |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |  |  |
| 3. | What do you consider the child’s strengths / interests? |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |  |  |
| 4. | Has the child been referred to  |  |  |  |  |  |
|  | Clinic appointment  | Yes | [ ]  | No | [ ]  | Date: |
|  | Two day assessment  | Yes | [ ]  | No | [ ]  | Date: |
|  | Combined / SCD Clinic  | Yes | [ ]  | No | [ ]  | Date: |
|  | Ryegate ASD Assessment  | Yes | [ ]  | No | [ ]  | Date: |
|  | Speech and Language Therapy  | Yes | [ ]  | No | [ ]  | Date: |
|  | Community Paediatric Clinic  | Yes | [ ]  | No | [ ]  | Date: |
|  | Physiotherapy/Occupational Therapy  |  | Yes [ ] No [ ] Date: |
|  | Assessment reports enclosed – Please Specify: |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **PLEASE INCLUDE COPIES OF ANY OTHER RELEVANT REPORTS OR INFORMATION****(Information for medical services is very helpful)** |
| 5. | Please Identify Other Support Received and Key Agencies Involved |
|  |  |
|  | **Name** | **Address** | **Tel** |
| **Consultant Paediatrician** |  |  |  |
| **G.P.** |  |  |  |
| **Speech & Language Therapist** |  |  |  |
| **Physiotherapist** |  |  |  |
| **Occupational Therapist** |  |  |  |
| **Health Visitor** |  |  |  |
| **Social Worker** |  |  |  |
| **Hearing Impaired Service**  |  |  |  |
| **Visually ImpairedService** |  |  |  |
| **Combined / SCD Clinic** |  |  |  |
| **MAST** |  |  |  |
| **0-5 Prevention** |  |  |  |
| **School Readiness**  |  |  |  |

**\* CHILDREN IN FS1 REQUIRING ASSESSMENT SHOULD BE REFERRED BEFORE THE CHRISTMAS HOLIDAY IN ORDER THAT WE HAVE TIME TO ALLOCATE AND ASSESS NEEDS BEFORE TRANSITION INTO SCHOOL. FOR EXCEPTIONAL CASES OUTSIDE THIS TIMEFRAME, PLEASE CONTACT THE TEAM MANAGER** **Richard.Redman@sheffield.gov.uk** **TO DISCUSS BEFORE REFERRING.**

**\* PLEASE NOTE WE DO NOT ACCEPT REFERRALS FOR FS2 CHILDREN WHO HAVE PREDOMINANTLY SOCIAL COMMUNICATION DIFFICULTIES. PLEASE REFER TO THE AUTISM SOCIAL COMMUNICATION (ASC) TEAM – 0114 2506800 FOR THEIR REFERRAL PROCESS.**

**NEW REFERRALS FOR CHILDREN IN FS2 SHOULD ONLY BE MADE FOR CHILDREN AT LEVELS 4 AND/OR 5 ON THE EY SHEFFIELD SUPPORT GRID. OTHER CHILDREN WILL BE PROVIDED FOR WITHIN THE SEN SUPPORT STAGE OF THE CODE OF PRACTICE FOR SEND 2014 AND WITHIN THE LOCALITY MODEL.**

|  |  |
| --- | --- |
| 6. | If the child attends nursery, please name the setting group and indicate which sessions are attend (IF etc.) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |  |  |
| 7. | Please complete the below after having assessed the child’s level of needs according to the descriptors on the Early Years Sheffield Support Grid.  |
|  |  |  |  |  |  |  |
|  |  |  | **Level** |  |  | **Level** |
| Communication and Interaction | Speech and Language **DfE Code: SLCN** |  | Sensory and / or Physical | Visual Impairment **DfE Code: VI / MSI** |  |
| Social Communication **DfE Code: ASD** |  | Hearing Impairment **DfE Code: HI / MSI** |  |
| Cognition and Learning | Learning**DfE Code: MLD / SLD / PMLD** |  | Physical **DfE Code: PD** |  |
| Social, Emotional and Mental Health | Emotional Regulation**DfE Code: SEMH** |  | Medical |  |
| Mental Health**DfE Code: SEMH** |  |  |  |  |
|  |  |  |  |
| 8. | Please add any additional information which you consider to be relevant. For example, **Request to assess for an EHCP completed.****(Please include info about any serious childhood illness)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 9. | Please attach 2 copies of the Assess, Plan, Do Review (APDR) cycles to evidence interventions and provision you have made in your setting to support the child’s needs.  |
|  |  |  |  |
|  | **Number of APDR’s** |  |
|  |  |  |  |
| 10.  | Please attach at least one set of review meeting minutes to evidence your discussions with parents / careers.  |
|  |  |
|  | **Number of minutes**: |  |
|  |  |
| 11. | Please attach copies of pertinent observation, progress, development records to the form and indicate documents enclosed in the box below. **(e.g. setting progress tracking/assessment, Locke and Beech Profile, B Squared)** |
|  |  |
|  |  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |  |
|  | We cannot progress this referral without this information. If this is not received this referral will **NOT** be accepted. |

**THIS FORM MUST BE FILLED IN WITH PARENTS/CARERS.**

**Ethnic background record form (based on the new national population Census ethnic categories).**

Child’s name …………………………………………………………………………………………………

Our ethnic background describes how we think of ourselves. This may be based on many things, including, for example, our skin colour, language, culture, ancestry or family history.

**Ethnic background is not the same as nationality or country of birth.**

Please study the list below and tick **one box only** to indicate the ethnic background of the child named above.

**White**

* British [ ]
* Irish [ ]
* Traveller of Irish Heritage [ ]
* Gypsy/Roma [ ]
* Any other White background [ ]

**Mixed**

* White and Black Caribbean [ ]
* White and Black African [ ]
* White and Pakistani [ ]
* White and any other Asian background [ ]
* Any other mixed background [ ]

**Asian or Asian British**

* Indian [ ]
* Pakistani [ ]
* Bangladeshi [ ]
* Any other Asian background [ ]

**Black or Black British**

* Caribbean [ ]
* Somali [ ]
* Other Black African [ ]
* Any other Black background [ ]

**Chinese** [ ]

**Any other ethnic background**

* Yemeni [ ]
* Any other ethnic background [ ]

**I do not wish an ethnic background category to be recorded.** [ ]

**Please indicate:**

|  |  |
| --- | --- |
| First language spoken by parents/carer |  |
| First language spoken by child |  |
| Second language spoken by parents/carer |  |
| Second language spoken by child |  |

*Any information you provide will be used to compile statistics of children from different ethnic backgrounds, to help ensure that all children have the opportunity to fulfil their potential. The information may be passed on to future schools.*