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| **ADMIN USE ONLY** | | | |
| Capita |  | E-Record Form |  |
| Database Spreadsheet |  | Date Received: | |
| E-Start |  |

**Early Years SEND Request for Involvement**

This form should be submitted by email to **eysend@wirral.gcsx.gov.uk** and on receipt of the referral form, if family found not to be registered with the Children’s Centres, this form will generate an automatic registration in order to receive services. The referral must be completed in **full** and **must** be signed by the parent/carer indicating that they are consenting to the referral and to information sharing where appropriate.

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| **Parent/Carer Consent**  Parental consent must be obtained before a referral is made. Verbal consent is not acceptable and the referral will be rejected without a penned signature. | | | | |
| I agree to my child being referred to the Early Years SEND Team and for me to be registered with Wirral Children’s Centres, and the information to be shared with the Educational Psychologists. | | | | |
| Print Name: | Sign: | | Date: | |
| **Request For Involvement**  Please tick which involvement is being requested and complete the appropriate sections | | | | |
| Portage Educational Home Service **(please complete Section A and Section B)** | | | |  |
| Intervention for Child based in a Setting **(please complete Section A and Section C)** | | | |  |
| Is there a sibling in the family which has been referred for SEND 0-5 services before?  YES  NO (Please state name of worker if known) | | | | |
| **Referrer Details** | | | | |
| Referral Source: Health 0-19  Speech and Language  School/Setting  Parent/Self | | | | |
| Full Name: | |  | | |
| Job Role: | |  | | |
| Contact Tel No: | |  | | |
| Contact Email Address: | |  | | |
| Date of Referral: | |  | | |

**Section A – Child/Family Details**

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| --- | --- | --- | --- | --- | --- | --- |
| **Child** | | | | | | |
| Full Name: | | | |  | | |
| DOB (dd/mm/yyyy): | | | |  | | |
| Age: | | | |  | | |
| Gender: | | |  | | |
| Ethnicity: | Any Other Asian Background  Any Other Black Background  Any Other Ethnic Group Any Other Mixed Background  Bangladeshi  Black African  Black Caribbean  Chinese  Gypsy/Roma  Indian  Pakistani  Traveller of Irish Heritage  White and Asian  White and Black African  White and Black Caribbean  White British  White Irish | | | | | |
| Please identify safeguarding status if relevant. **Please attach PEP document, if CLA.** | | | | | TAF  CIN  CP  CLA  PCLA | |
| **Family** | | | | | | |
| Name of Parents/Carers: | |  | | | | |
| Family Address including postcode: | |  | | | | |
| Telephone Number: | |  | | | | |

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| **Funding** |
| Is there an EHCP assessment currently in place? YES  NO  APPLIED |
| Is the child in receipt of Inclusive Practice Fund? YES  NO  APPLIED |
| Is the child in receipt of Disability Living Allowance? YES  NO  APPLIED |
| Is the child in receipt of Disability Access Fund? YES  NO  APPLIED |
| Is the child in receipt of Early Years Pupil Premium? YES  NO  APPLIED |

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| **Professionals Currently Involved with the Family** | | |
| Service/Agency: | Named Professional: | Telephone No: |
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**Section B - Request for Portage**

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| --- | --- |
| **Primary Area of Need**  **Please tick only one, the most primary** | |
| Communication and Language |  |
| Cognition and Learning |  |
| Social, Emotional and Mental Health |  |
| Sensory and/or Physical |  |

|  |
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| **Setting Aspirations**  Please give details of the setting aspirations for the child. For example, the future setting the child would like to attend, if the parent/carer intends on applying and when. |
|  |

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| **Concerns** |
| Please give details of concerns surrounding the child and why involvement is being requested? |
|  |
| **Outcomes** |
| What outcomes do you hope to achieve for the child from this request? |
|  |
| **Home Visits** |
| Details of identified risks for home visits of lone working: |

**Section C - Request for SEND Intervention**

|  |  |
| --- | --- |
| **Supporting Evidence**  Please tick to confirm you have attached at least one of the following. Referral will be returned if there is no supporting evidence attached. | |
| Asses, Plan, Do, Review |  |
| One Page Profile |  |
| Additional Support Plan / Play Plan |  |

|  |  |
| --- | --- |
| **Primary Area of Need**  **Please tick only one, the most primary** | |
| Communication and Language |  |
| Cognition and Learning |  |
| Social, Emotional and Mental Health |  |
| Sensory and/or Physical |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Setting Details** | | | | | |
| Name of Setting: |  | | | | |
| Address including Postcode: |  | | | | |
| Telephone Number: |  | | | | |
| Days/times the child attends: | Monday | Tuesday | Wednesday | Thursday | Friday |
|  |  |  |  |  |

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| --- |
| **Concerns** |
| Please give details of concerns surrounding the child and why involvement is being requested? |
|  |
| **Outcomes** |
| What outcomes do you hope to achieve for the child from this request? |
|  |