Referral form for Solihull EYTAC
(Early Years Team around the Child)
Early Years Team (SEND) and Solihull Speech and Language Therapy

Please return completed forms to:

Early Years Team or

Solihull Inclusion Support Service - Sensory and Physical Impairment Team

email: tacpanelreferrals@solihull.gov.uk

and Speech and Language Therapy

email: paediatric.speechlanguage@nhs.net

If you have any other queries regarding this form, please call: 0121-704-6150. Please note that this form is **not** for parents/carer(s) to complete.

Child's details		
Child's Name:	**Date of Birth:**	**Male** ☐
Address:		**Female** ☐
	Is this child looked after by local authority? YES ☐ NO ☐	
Postcode:	**No of children in family:**	**Position of child in family: e.g. 2nd of 3:**

Parent/carer/carer details	
Please provide full names and addresses (if different) of each parent/carer(s) responsible for the child. Please indicate who has parental/carer responsibility.	
1. Name:	**2. Name:**
Relationship to child:	**Relationship to child:**
Address: **Postcode:**	**Address:** **Postcode:**
Contact no:	**Contact no:**
Mobile no:	**Mobile no:**
Email address:	**Email address:**

Child's GP details	
Name of GP:	**NHS Number:**
Address of GP: **Postcode:**	
Referrer details	
Name and contact details of referrer:	
Job role:	**Date:**
To be completed if child is attending an Early Years setting (or due to attend soon)	
Name of setting/school:	
Number of hours attending:	
Times attending:	
Name of SENCo/contact details:	
Family context: (Please provide any family information that you feel will be helpful including wishes of parent/carer(s). This may include languages spoken by the family)	
Please summarise additional information that evidences the child development assessment	
Health Does the child have: • Any existing medical needs? • A diagnosis? • Any regular medication? • A Care Plan? If so please attach • Did child pass their newborn hearing screening?	**Please explain your information further:**

Please specify service requested:

Health teams:	**Please tick**	**Re-referrals** add date returned
Children's speech and language therapy https://childrenscommunitytherapies.uhb.nhs.uk/speech-and-language-therapy/	☐	Date of re-referral:
Education teams: *choose either EY or SPI*		
Early Years Area SENCo – this support is referred through the Solihull early years group setting.	N/A setting referral	N/A
Early Years Home Support Service (the Early Years Team) for children with three or more areas of significant difficulty who do not attend a group setting. https://www.solihull.gov.uk/Children-and-family-support/localoffer/Early-Years-Team ***OR***	☐ ***OR***	Date of re-referral:
Sensory and Physical Impairment Team (Specialist Inclusion Support Service) https://www.solihull.gov.uk/children-and-family-support/localoffer/Sensory-and-physical-impairment-team Multi-sensory impairment Visual impairment Hearing impairment Physical disabilities	☐	Date of re-referral:

Re-Referral additional information: completed by _____
Please make and additional information clear (font colour, underline, bold)

Key person if different from above _____

Please summarise the main concerns/further actions required through this re-referral…..

Please identify other professionals involved with this child			
Professional	**Name**	**Telephone number/ Email address**	**Base**
Health visitor			
Paediatrician			
Speech and language therapist			
Physiotherapist			
Occupational therapist			
Educational psychologist			
Social worker			
Hospital specialists			
Other			

Please outline the key points from observations and discussion with parent/carer(s):	
Personal, social, and emotional	**Play**
Communication and language	**Physical development**
Sensory development **Are there any concerns with vision or hearing?** YES ☐ NO ☐	**Independence**

Child development summaries

To be completed by referrer and supported by other professional involved where possible. Please complete both sections if you can, using your professional judgement and as much information as you have been able to observe.

Ages and Stages Questionnaire (ASQ) summary 1

Date ASQ was completed: _____ Age at assessment (in months):_____

Please indicate *cut off* levels, as indicated on the final page of the ASQ, in the grid below and mark the child's score x in each area.

Child development ASQ summary

black	**/ / / / / / / / / grey / / / / / / /**	***White***
Consider referral	Development needs - monitor	*No or low risk*

Area	0	5	10	15	20	25	30	35	40	45	50	55	60	Wh/grey/bl
Communication														
Gross motor														
Fine motor														
Problem solving														
Personal and social														

Social and emotional	Child's score_____ Cut-off score _____

Child development summary 2

Child's chronological age _____

Please indicate a best fit judgement [x] for the child's skills' level in each area based on your observations, as represented by the 6-month age banding. This will show a child's area of difficulty and the significance of the developmental delay.

3 - 3 ½ years					
2 ½ - 3 years					
2 - 2 ½ years					
1 ½ - 2 years					
1 – 1 ½ years					
6mths – 12 mths					
0 to 6 months					
Represents 'typical' development level milestones	Personal, social and emotional	Communication and language	Physical development	Play	Independence

The following factors will delay the referral process:

- Incomplete information provided
- Inability to authenticate current address and phone numbers

Please Note:

- The person referring the child/young person must be of a professional nature i.e. health visitor, doctor, paediatrician, nurse, SEND practitioner etc. Parent/carer(s) cannot refer their child directly through this form.
- Parent/carer(s) consent: **No referral will be accepted without consent.**

PARENT/CARER CONSENT FORM

Any information that you provide will be used by local authority/health services to help us tailor services for your child. Your information will be treated as confidential and stored in a secure way. It will only be shared with other council services and partner organisations to ensure our records are kept accurate. The staff from the team working with your child will report on assessment and/or intervention findings and discuss with you and the school/nursery the action and support which will need to be followed.

We may also need to share your information for the prevention and detection of fraud and/or other crimes or as the law requires. For further information about how we use your information please refer to the Council's privacy statement on www.solihull.gov.uk or contact eyenquiries@solihull.gov.uk.

Your records will be kept for 25 years for audit purposes and in the event we need to provide information about the service you have received.

	Yes	No
• I confirm I understand why you want my information and I have had the opportunity to consider this.	☐	☐
• I agree that the information will be shared with other professionals who are already involved with my child, or other agencies that may become involved in the course of any support offered to my child. This will be done in accordance with Solihull's MBC information sharing protocols. This will only be information that is relevant and necessary and will only be shared with people who need that information at that time.	☐	☐
• I understand I can opt out and withdraw my consent at any time by contacting the Early Years Team on 0121 704 6150 or via email at eyenquiries@solihull.gov.uk	☐	☐
• I give consent for you to record and hold my information for the purposes explained to me.	☐	☐
• **I confirm that everyone who qualifies as a "parent" under education law is aware of this application and agrees with the content.**	☐	☐

Name of parent/carer: _____ *(please print)*

Signature: _____

Email address: _____

Date: _____

If consent is received via phone/e-mail, then the referrer is confirming that the parent/carer has agreed to all the above actions. The referrer is accountable for the parent/carer agreement to store information and pass information on to referred services.

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*Where a child **is re-referred** the parent/carer must agree to **further referrals***

Name of parent/carer: _____ *(please print)*

Signature: _____

Date: _____

Referral request for: _____