 SW-NHS-FT-Email-Signature-650X107 

**Referral form for Solihull EYTAC**

**(Early Years Team around the Child)**

**Early Years Team (SEND) and Solihull Speech and Language Therapy**

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| **Please return completed forms to:**  Early Years Team or  Solihull Inclusion Support Service - Sensory and Physical Impairment Team  email: [tacpanelreferrals@solihull.gov.uk](mailto:tacpanelreferrals@solihull.gov.uk)  and Speech and Language Therapy  email: [paediatric.speechlanguage@nhs.net](mailto: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:**  **Postcode:** | | | **Female** ☐ |
| **Is this child looked after by local authority?**  YES  NO | |
| **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) | | | | |
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| **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:**

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| **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….. | | |

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| **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** |  |  |  |

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| **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** |

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| **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 | | | |  | | | | | | | | | | | | | | | | | | | |

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| **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](http://www.solihull.gov.uk) or contact [eyenquiries@solihull.gov.uk](mailto: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](mailto: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.*  **---------------------------------------------------------------------------------------------------------------------------***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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |