Early Years Service (EYS) Referral Form

**For children with disabilities, complex special educational needs and/or social and emotional difficulties. Please complete this form with parent/carer in BLOCK CAPITALS.**

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| **Section A – Child’s Details** |
| **Surname:** |  | **Forenames:** |  |
| **Date of Birth:** | dd/mm/yyyy | **Gender:** | Male [ ]  | Female [ ]  | Other [ ]  |
| **Address:** |  |
| **Town:** |  | **Postcode:** |  |
| **Telephone:** |  | **Mobile:** |  |

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| **Child’s First Language:** |  | **Parent/Carers First Language:** |  |
| **Interpreter / Signer required?** | Yes |[ ]  No |[ ]  **Has this been arranged?** | Yes |[ ]  No |[ ]
| **Any medical conditions?** | Yes |[ ]  No |[ ]  **Looked after by Local Authority?** | Yes |[ ]  No |[ ]
| **If ‘Yes’, please give more details:** |  |

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| **Section B – Parent / Carer Details** |
| **Title:** |  | **Surname:** |  | **Forename/s:** |  |
| **Relationship to Child:** |  | **Parental Responsibility:** | Yes |[ ]  No |[ ]
| **Address if different to above:** |  |
| **Email address:** |  |

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| **Title:** |  | **Surname:** |  | **Forename/s:** |  |
| **Relationship to Child:** |  | **Parental Responsibility:** | Yes |[ ]  No |[ ]
| **Address if different to above:** |  |
| **Email address:** |  |

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| **Section C – Referrer Details** |
| **Referred by:** |  | **Job Title:** |  |
| **Address:** |  |
| **Postcode:** |  | **Telephone:** |  |
| **Email Address:** |  | **Mobile:** |  |

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| **Section D – Referral Details** |
| Have any of the following been carried out? (If yes, please attach copies to this referral form or provide full details on separate page. |
| **Hearing** | **Vision** | **ESCC Language Checker** | **ESCC Speech, Language and Communication Monitoring Tool** | **Ages and Stages Behavioural Questionnaire (ASQ)** | **Schedule of Growing Skills (SOGS)** |
| Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| Has the child been referred to Toddler Talk or Small Beginnings: |
| Toddler Talk | Yes [ ]  | No [ ]  | Small Beginnings: | Yes [ ]  | No [ ]  |

**Involvement of other agencies:**

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| **Agency** | **Key Name** | **Role** | **Address** | **Telephone Number** |
| Social Care  |  |  |  |  |
| Education e.g., pre-school  |  |  |  |  |
| Health Visitor  |  |  |  |  |
| GP |  |  |  |  |
| Speech & Language Therapist  |  |  |  |  |
| Paediatrician  |  |  |  |  |
| Physiotherapist  |  |  |  |  |
| Occupational Therapist  |  |  |  |  |
| Other  |  |  |  |  |

**Reason for referral:**

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| **Speech, Language and Communication skills** | **Please provide details/comments** |
| Please tell us your concerns  |  |
| How does the child communicate his/her needs?  |  |
| How does he/she respond to language? |  |
| Is she able to attend / listen? | Yes |[ ]  No |[ ]   |

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| **Play & Learning** | **Please provide details/comments** |
| Please tell us about the kind of play the child chooses/enjoys  |  |
| Is play solitary / alongside /co-operative? | Solitary |[ ]  Alongside |[ ]  Co-operative |[ ]
| Is she able to attend / listen? |  |
| Yes |[ ]  No |[ ]   |

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| **Play & Learning** | **Please provide details/comments** |
| Please tell us about the kind of play the child chooses/enjoys  |  |
| Is play solitary / alongside /co-operative? | Solitary |[ ]  Alongside |[ ]  Co-operative |[ ]
| Can the child share and take turns with other adults/children? |  |
| Yes |[ ]  No |[ ]   |
| Does the child have any unusual intense interests? |  |
| Yes |[ ]  No |[ ]   |

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| **Sensory** | **Please provide details/comments** |
| Is the child particularly sensitive to light / touch /smell / textures / noise? |  |
| Yes |[ ]  No |[ ]   |
| Are there any difficulties during mealtimes? |  |
| Yes |[ ]  No |[ ]   |
| Does the child display any unusual repetitive behaviours? I.e. rocking, hand flapping, spinning etc. |  |
| Yes |[ ]  No |[ ]   |
| **Additional Comments**: |

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| **Social / Emotional Development** | **Please provide details/comments** |
| Is the child able to follow familiar routines / expectations in the pre-school setting? |  |
| Yes |[ ]  No |[ ]   |
| Is the child able to follow familiar routines in the home? |  |
| Yes |[ ]  No |[ ]   |
| Does the child separate from parent/carer positively into pre-school?  |  |
| Yes |[ ]  No |[ ]   |
| Does the child have tantrums? | If yes, what are the triggers? |
| Yes |[ ]  No |[ ]   |

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| **Specific Behavioural concerns** | **Please provide details/comments** |
| Is the child displaying anti-social behaviour? E.g., fighting, bullying, swearing etc |  |
| Yes |[ ]  No |[ ]   |
| Is the child displaying oppositional behaviour? E.g., refusing requests, sulking, running away |  |
| Yes |[ ]  No |[ ]   |
| Is the child highly irritable, inattentive, impulsive, anxious, excessively fidgety, whiny or experiencing sleep disturbance? |  |
| Yes |[ ]  No |[ ]   |
| Is the child highly disruptive? E.g., throwing objects, shouting and attention seeking? |  |
| Yes |[ ]  No |[ ]   |
| Are these behaviours displayed across both home and pre-school setting? |  |
| Yes |[ ]  No |[ ]   |

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| **Additional Information** |
| List any particular strategies that are successfully used to support this child in the home/pre-school |  |
| Can you tell us about the child’s gross/fine motor skills and spatial awareness |  |
| Please tell us about the child’s self-help skills |  |
| Are there any known significant social or environmental factors that you feel impact on the child’s development/behaviour? E.g. temporary accommodation, substance misuse, parental mental health issues, loss or bereavement? |  |
| Please state what outcome you would expect to achieve from the ISEND Early Years Support Service input. |  |

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| **Section E – Nursery Details** |
| **Pre-school/Nursery name:** |  |
| **Telephone Number:** |  |
| **Email Address:** |  |
| **Child Attends:** |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| AM [ ]  | PM [ ]  | AM [ ]  | PM [ ]  | AM [ ]  | PM [ ]  | AM [ ]  | PM [ ]  | AM [ ]  | PM [ ]  |

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| **Section F – Referrer Signature** |
| **Signed by referrer:** |  | **Date:** | Click or tap to enter a date. |

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| **Section G – Parental Consent (please tick boxes below)**In giving my consent to the ISEND Early Years’ Service, I understand the following (please tick all boxes) |
| I understand my child’s information may be shared with other agencies when it is in his/her best interests, or if co-ordination of services is needed to provide support to my child and family. |[ ]
| I understand that ISEND’s case management system (EYES) will show that my child is known to the ISEND Early Years’ Service. |[ ]
| I can withdraw my consent at any time by contacting eys@eastsussex.gov.uk (*please allow 7 days for your request to be processed*). |[ ]
| Based on the above I hereby give consent for a referral to the ISEND Early Years’ Service |[ ]
| **Signed by parent / carer:** |  | **Date:** | Click or tap to enter a date. |
| **PRINT NAME:** |  |

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| **Parent / Carer views about their child:** |
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**Child’s Ethnic Origin**:

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| --- | --- | --- | --- | --- |
| **White** | **Black/Black British** | **Asian/Asian British** | **Mixed** | **Any other Ethnic Group** |
| British |[ ]  Caribbean |[ ]  Pakistani |[ ]  White & Black Caribbean |[ ]  Chinese |[ ]
| Irish |[ ]  African |[ ]  Indian |[ ]  White & Black African |[ ]  Other Ethnic Group |[ ]
| Other White |[ ]  Other Black |[ ]  Bangladeshi |[ ]  White & Asian |[ ]  Gypsy/Roma |[ ]
| Other Mixed |[ ]   | Other Asian |[ ]   | Traveller of Irish Heritage |[ ]
|  | Not given |[ ]

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| **Please return this form to:**  | **Address** | Early Years’ Service3rd Floor, Ocean House87 – 89 London RoadSt Leonards on SeaEast SussexTN37 6DH  |
| **Telephone No.** | Tel: 01273 335270 |
| **Email** | Email: eys@eastsussex.gov.uk |