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CONFIDENTIAL

FORM EY/SESS

SPECIAL EDUCATION SUPPORT SERVICE

EARLY YEARS REFERRAL FORM

LAST NAME OTHER NAMES

DATE OF BIRTH SEX

DATE OF REFERRAL

ADDRESS

HOME ADDRESS (if different from above)

HOME PHONE NO: G.P.

NAMES OF PARENTS/CARERS

REASON FOR CONCERN (Please provide as much information as possible and append Early Years Record of Concern if available and other reports)

WHAT DO YOU HOPE TO ACHIEVE FOR THE CHILD FROM THIS REFERRAL?

CONSIDERATION FOR PORTAGE SCHEME (including initial developmental assessment)

ADVICE OR ASSESSMENT FROM AN EDUCATIONAL PSYCHOLOGIST

ADVICE OR ASSESSMENT FROM VISION SUPPORT

ADVICE OR ASSESSMENT FROM HEARING SUPPORT

MEDICAL/PHYSICAL ADVICE

<u>PROFESSIONALS INVOLVED</u>	<u>NAME</u>	<u>LOCATION</u>
CONSULTANT COMMUNITY PAEDIATRICIAN OR OTHER COMMUNITY PAEDIATRICIAN	<input type="text"/>	<input type="text"/>
HOSPITAL CONSULTANTS	<input type="text"/>	<input type="text"/>
PHYSIOTHERAPIST	<input type="text"/>	<input type="text"/>
OCCUPATIONAL THERAPIST	<input type="text"/>	<input type="text"/>
SPEECH AND LANGUAGE THERAPIST	<input type="text"/>	<input type="text"/>
SOCIAL SERVICES SOCIAL WORKER	<input type="text"/>	<input type="text"/>
OTHER RELEVANT PROFESSIONALS	<input type="text"/>	<input type="text"/>

GROUPS INVOLVED:

E.G. TOY LIBRARY, CHUC, EARLY EDUCATION SETTING, SCHOOL FOR PARENTS, SURESTART

PLEASE TICK IF CHILD IS - LOOKED AFTER BY THE LOCAL AUTHORITY

ON THE CHILD PROTECTION REGISTER

SOCIAL SERVICES AREA OFFICE

HAVE YOU DISCUSSED THIS CHILD WITH A MEMBER OF THE SPECIAL EDUCATION SUPPORT SERVICE? IF SO, PLEASE STATE NAME AND OCCASION

PARENTAL PERMISSION CLAUSE (requires parental signature)

I AGREE TO MY CHILD BEING REFERRED TO THE SPECIAL EDUCATION SUPPORT SERVICE

_____ PARENT

_____ DATE

REFERRED BY:

DESIGNATION:

DATE:

SIGNATURE:
