

|  |
| --- |
| **Request Form for involvement with**  **Emotional Health and Well Being – EARLY YEARS** |
| **Portage, Behaviour Support Team (2-12), Educational Psychology Services, Autism Spectrum Education Team (ASET), Complex Behaviour Team, Children’s Centre,**  **North Lincolnshire Neurodevelopment Assessment Pathway (ASD) – (3-Under 5’s)**  **and 0-19 (25 SEND) Health and Wellbeing Service** |

|  |  |
| --- | --- |
| **Name of the Child/Young Person for whom this request is made** |  |
| **Gender** | **Male Female** |
| **DOB & NHS Number** |  |
| **Address** |  |
| **Telephone number** |  |
| **Ethnicity & Religion** |  |
| **Any known disability?** | |
| **Referrer’s Details** | |
| **Name** |  |
| **Team/Service/Parent** |  |
| **Address** |  |
| **Telephone number** |  |
| **E mail:** |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **School/ Nursery/Pre-school/Childminder** | | | | | | | | |
| **Name/address/contact number:** |  | | | | | | | |
| **Days and times of sessions** | **Monday** | | **Tuesday** | | **Wednesday** | **Thursday** | | **Friday** |
| **Does the child attend more than one childcare setting,** | **If so please give all details** | | | | | | | |
| **Does the child receive funding to attend? (please tick/give details)** | **Yes** | **No** | | **Give details (2/3/4 year funding/inclusion funding, etc)** | | | | |
| **Due to start School date:** | **School** | | | | | | **Date** | |

|  |  |
| --- | --- |
| **Please give brief details of the reason for the request and description of need:** |  |
| **What would you like as an outcome of the request?** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parent/Carer Details** | | | | |
| **Name** |  | |  | |
| **Relationship to child** | **Mother /Father /Carer** | | **Mother /Father /Carer** | |
| **Parental Responsibility**  **(please tick)** | **Yes** | **No** | **Yes** | **No** |
| **Looked after child (please tick)** | **Yes** | **No** | **Name of social worker** | |
| **Home Language** |  | | | |
| **Is an interpreter required? (Please tick)** | **Yes** | | **No** | |

|  |  |  |
| --- | --- | --- |
| **Assessments** | |  |
| **Please include a copy of the Early Help assessment (also include most recent plan where relevant)**  **Or are there any other meetings in place for the child, for example Child in need, Child Protection etc (please state)** | | |
| **Who is the lead professional/Chair?** |  | |
| **When is the next scheduled meeting and where?** | **Date:** | |
| **Time:** | |
| **Venue:** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other professionals involved?** | | | |
| **Agency** |  | **Name** | **Contact Number** |
| **Autism Spectrum Education Team** |  |  |  |
| **Behaviour Support Team (2-12)** |  |  |  |
| **Child Adolescent Mental Health Service** |  |  |  |
| **Child Development Centre** |  |  |  |
| **Complex Behaviour Team** |  |  |  |
| **Consultant** |  |  |  |
| **GP** |  |  |  |
| **Health Visitor** |  |  |  |
| **Occupational therapy** |  |  |  |
| **Paediatrician** |  |  |  |
| **Physiotherapy** |  |  |  |
| **Portage** |  |  |  |
| **Speech and Language therapy** |  |  |  |
| **Social care/ Social Worker** |  |  |  |
| **School Nurse** |  |  |  |
| **Any other service (please name)** |  |  |  |
| **What strategies and/or advice have been used to date:** | | | |

**Please complete SECTIONS A and B**

|  |  |
| --- | --- |
| **SECTION A – For completion by Referrer**  I have discussed this request with the parents/carers | |
| **Referrers Signature** | **Date** |
| **SECTION B - For completion by parent/carer of the child. (Signature MUST be provided)** | **Please Tick** |
| I give permission for the referral. |  |
| I give permission to share information with other relevant professionals |  |
| I give permission for information to be stored on North Lincolnshire Council’s database |  |
| I give permission for information to be stored on Health database |  |
| **Parent/Carer Signature** | **Date** |
| **\**Box A and B must be completed before sending***  **Please note the form will be returned if parents/carers signature is not recorded.** | |

|  |  |
| --- | --- |
| **Please include the following REQUIRED items**  (if documents are not received this may result in the delay of allocation) | **Please tick items you have included to support this request** |
| Early Help Assessment |  |
| EYFS/ 1-10 Continuum documentation |  |
| Observations |  |
| Recent reports from other professionals involved (with their permission) |  |
| Behaviour toolkit, behaviour logs and evaluations or/and ASET support and strategies document |  |

|  |
| --- |
| **Please send this form to:-** |
| **Emotional Health and Well-being**  **Side by Side Children’s Centre**  **Enderby Road**  **Scunthorpe**  **North Lincolnshire**  **DN17 2JL**  **Telephone: 01724 296679**  **Or**  **E mail:NLPortage@northlincs.gov.uk** |