

**Early Years SEN Advisory Service**

**PVI Referral Form**

This form is to be used when making a referral into SEN Advisory Service.

The form must be completed in full by the PVI setting and with consent from the parent/carer.

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| **Date of Referral** | Click here to enter. |
| **Section 1. Setting Details**  |
| **Setting Name**  |  |
| **Setting Address**  |  |
| **Contact Name**  |  | **Position** |  |
| **Contact Number** |  |
| **Email Address** |  |
| **Section 2. Child Details**  |
| **Name** |  |
| **Gender** | Choose an item. | **Date of Birth**  | Click here to enter. |
| **Home Address** |  |
| **First Language** |  |
| **Ethnicity** | Choose an item. |
| **Religion** | Choose an item. |
| **What is the child’s main areas of need** | Choose an item. |
| **Does your setting receive Early Years SEND Funding for the child?** | Choose an item. |
| **Please provide below the days and times when the child attends your setting**  |
| **Monday**  |  |
| **Tuesday**  |  |
| **Wednesday**  |  |
| **Thursday**  |  |
| **Friday**  |  |
| **Section 3. Parent/Carer and Family Details**  |
| **Name**  |  |
| **Relationship to Child**  | Choose an item. | **Parent Responsibility** | Choose an item. |
| **Address (if different to Child’s)** |  |
| **Contact Number** |  |
| **Email Address** |  |
| **First Language** |  |
| **Please list below any other children or adults within this family/household** |
| **Name, DOB & Age** | **Relationship** |
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| **Section 4. Health Visitor Information**  |
| **Name** |  |
| **Health Visitors must be aware of any referrals to SENAS. Please confirm the date you informed the Health Visitor.**  | Click here to enter. |
| **Section 5. Services Working with the Child/Family**  |
| **Please list below any services working with the family (e.g. GP, School, Social Worker, Early Help)**  |
| **Profession**  | **Name**  |
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| **Section 6. Referral Information**  |
| **What are your main concerns?** |
| **What work has already been completed to support the child/family?** |
| **What are you and the family expecting from this referral?** |
| **Are there any known risks if a home visit was to be carried out?** | Choose an item. |
| **If Yes, please provide details** |
| **WellComm Assessment Score** |  | **Date of Assessment** | Click here to enter. |
| **Early Years Development Journal (EYDJ)** |
| **Communication** | Enter step | **Thinking**  | Enter step | **PSED**  | Enter step | **Physical** | Enter step |
| **Section 7. Consent** |
| **Is the parent/carer aware of this referral?** | Choose an item. |
| **Any comments from the parent/carer**  |
| In submitting this form, I confirm that I have obtained consent and that the parent/carer understand that information will be shared (where appropriate) between relevant professionals including the Trafford Care Coordination Centre. |