**Specialist Education Services (SES)**

**Referral Form for the Sensory Service: Individual Pupils - Deaf Services (HI), Vision Service (VI), Multi-Sensory Impairment Service (MSI),**

This referral form should be used to request the support of the HI, VI, MSI (for pupils with **clinically diagnosed HI/VI/MSI sensory loss**, not pupils with sensory processing difficulties) Send to: SESReferrals@suffolk.gov.uk Incomplete referrals will be returned.

In line with GDPR regulations, please send this form via an encrypted email (e.g. OME) stating **OFFICIAL-SENSITIVE** in the subject field. ***Signatures will be taken as full permission to progress this referral; please see additional information regarding parental signatures in section 8.***

Please **do not** use this form for referrals for Alternative Provision, Specialist Provision (including Specialist Units), Permanent Exclusions, IYFAP and the Alternative Tuition Service (ATS). Please use the [Inclusion Referral Form](https://suffolklearning.com/inclusion/specialist-education-services/) and send to **InclusionService.Referrals@suffolk.gov.uk****.**

**Section 1: Agreement and request**

Please note:

* How we will use your data: <http://www.suffolk.gov.uk/CYPprivacynotice>.

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| **Specialist Education Service Request(s)****(Appendix must be completed where there is a \*)** |
| Vision Service |[ ]
| Deaf Service |[ ]
| Multi-Sensory Impairment Service  |[ ]

**Section 1: Pupil details**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname (capitals) |  | Forename(s) |  |
| Date of birth |  | Current NCY |  | UPN |  |
| Gender |  |
| Current education setting |  |

|  |  |
| --- | --- |
| Address (where currently living) including postcode |  |
| Contact number(s) for home |  |
| Home language 1 |  | Ethnicity | Ethnicity. |
| Home language 2 |  | Nationality |  |

**Social Care**

|  |  |
| --- | --- |
| Child in Need |[ ]  Child Protection 0-18 |[ ]
| Child in Care 0-16 |[ ]  Court of Protection 18+ |[ ]
| Leaving Care 16+ |[ ]  Adult and Community Services 18+ |[ ]
| Early Help 0-18 |[ ]  Disabled Children and Young People 18+  |[ ]

**Child in Care (If applicable)**

|  |  |
| --- | --- |
| If a Child in Care, name of Authority  |  |
| Child in Care status |  |
| Social worker |  |

**SEND stage**

|  |
| --- |
| SEND Support |[ ]
| Education Health Care (EHC) Needs Assessment requested |[ ]
| Education Health Care (EHC) Needs Assessment started |[ ]
| Education, Health and Care (EHC) Plan  |[ ]

**Additional information**

|  |  |  |
| --- | --- | --- |
| Pupil Premium |[ ]  High Needs Funding Band |  |
| Current attendance: |  |

**Additional Area(s) of need**

|  |  |  |
| --- | --- | --- |
| **Areas of need** (select **only one** primary need) | **Primary** | **Additional** |
| Sensory / Physical (i.e***clinically diagnosed sensory loss and not sensory processing difficulties)*** |[ ] [ ]
| Communication and interaction (including SLCN) |[ ] [ ]
| Cognition and learning (including SpLD) |[ ] [ ]
| Social, emotional and mental health |[ ] [ ]

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| --- |
| **Clinical Diagnosis Details****Please give name of Ophthalmology or Audiology Clinic attended.****Please attach any clinical reports / audiograms you have available.****Does the pupil have any other diagnosed conditions?** (If yes, please specify what, when this was diagnosed and who by.) |
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| **Assessment/Attainment Data** (not necessary for referrals to SPLSS) |
| Current attainment (if pupil is working below age-related expectations, please indicate at what year group the pupil is working at): |
| Please describe the pupil’s academic progress over the last 2 terms. |
| Please indicate attainment at the last national reporting point: |
| GLD | Yes/No | Y1 Phonics /40Y2 Phonics (retake) |  |
| Y2 SATs | Y6 SATs | GCSE |
|  |  |  |

**Education history**

|  |  |
| --- | --- |
| **Known Previous Schools / Settings /** **EHE (Elective Home Education)** | **Dates attended** |
|  |  |
|  |  |
|  |  |
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**Section 2: Other professionals / services / agencies involved.**

**State if any other agencies are currently involved or have been in the last 6 months with this pupil and/or family and provide details of each agency’s key worker.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Key worker name** | **Contact details** | **Date of last contact** |
| Psychology and Therapeutic Services (P&TS) |  |  |  |
| Specialist Education Services (SES) other |  |  |  |
| Social Care (Please specify team) |  |  |  |
| Early Help (Please specify team) |  |  |  |
| Suffolk Youth Justice Service |  |  |  |
| Health (Please specify) |  |  |  |
| Mental Health Services (Please specify) |  |  |  |
| Other(s) please list below: |  |  |  |
|  |  |  |  |

**Section 3: Pupil and parent/carer views**

(If this cannot be gained, please explain why.)

|  |
| --- |
| **Pupil’s views** |
| **What is working well?****What are your strengths and interests?** |  |
| **What are your concerns? What do you find difficult?****What might help?** |  |
| **Parent/Carer views** |
| **What is working well?****What are your child’s strengths and interests?** |  |
| **What are your concerns? What does your child find difficult?****What might help?** |  |

**Section 4: School views**

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| --- |
| **Tell us what you understand the pupil’s additional needs to be, how the pupil is presenting and what are your concerns.** |
|  |

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| --- |
| **Tell us how you have supported the pupil’s needs so far and what impact this has had. Please include dates.** |
| Date | Strategies to support needs | Impact |
|  |  |  |

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| --- |
| **What are you hoping this referral will bring?** |
|  |

**Section 5: Referrer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Forename(s) |  | Surname |  |
| Role |  | Telephone |  |
| School or service |  |
| Address |  |
| Email |  |
| Signature |  | Date |  |

**Please complete details and permissions below.**

**Section 7: Parent / carer details**

Full name(s) of all persons with legal parental responsibility / carers (with addresses if different) and relationship to the pupil must be provided for this referral to progress.

|  |  |  |  |
| --- | --- | --- | --- |
| Surname  |  | Forename(s)  |  |
| Title |  | Relationship to child |  |
| Address (if different from pupil’s) | Parental responsibility? | Choose an item. |
|  | Telephone |  |
| Mobile |  |
| Postcode  |  | Email |  |
| Home language |  | Interpreter needed? | YES / NO |

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forename(s) |  |
| Title |  | Relationship to child |  |
| Address (if different from pupil’s) | Parental responsibility? | Choose an item. |
|  | Telephone |  |
| Mobile |  |
| Postcode  |  | Email |  |
| Home language |  | Interpreter needed? | YES / NO |

|  |  |
| --- | --- |
| Are any other communication adaptations required for parents/carers? If yes, please describe. | YES/NO |

**Section 8: Parent / carer permissions**

I / We the parent(s) / carer(s) are in agreement with the information included in this form and understand that:

* The referrer may attend a meeting about this pupil on our behalf regarding the information shared in this form.
* Personal information about me / my / our child may be shared with other professionals outside of SES who are, or have been, involved with me / my / our child and seek relevant information from them to decide what additional support or provision may be needed. **Please indicate here any exceptions:**
* Other professionals outside of SES may become involved should this be deemed helpful. **Please indicate here any exceptions:**

**Parent(s) / carer(s) signature**

Typed signatures will not be accepted.

|  |
| --- |
| **I confirm that I have read all the information on this form, including the SCC CYP Privacy notice** <http://www.suffolk.gov.uk/CYPprivacynotice> |
| Signature |  | Date |  |
| Signature |  | Date |  |

**All information contained within this referral form must be shared with the parent(s) / carer(s) and a signature must be obtained.**

**Forms will be returned and not processed until a signature is obtained.**