|  |  |  |
| --- | --- | --- |
| **Please indicate by ticking the appropriate box below:** | | |
|  | **Section 23 Notification ONLY**  by Healthcare professional | **Complete PART A only** |
|  | **Section 23 Notification AND**  **Early Years Coordination Team (EYCT) referral**  by Healthcare professional | **Complete PART A and PART B** |
|  | **Early Years Coordination Team (EYCT) referral ONLY**  by Non-Healthcare professional | **Complete PART A and PART B**  **any appropriate APPENDICES** |

*Incomplete forms will be automatically rejected and returned*

**PART A** *(For Section 23 and EYCT referrals)*

|  |  |  |  |
| --- | --- | --- | --- |
| **CHILD'S DETAILS** | | | |
| First Name: | | Last name: | |
| Gender at birth: Male Female | | Date of birth: | |
| Address: | | | |
| Parent email address: | | Telephone no: | |
| Ethnicity: | | Interpreter required: Yes  No  Language: | |
| Parent/Carer name/s: | | | |
| GP Name: | | GP address: | |
| Nursery/Educational setting:  Tick if **not** known to nursery/setting: | | | |
| Other professionals and services involved: | | | |
| **REFERRER’S DETAILS:** | | | |
| Name (PRINT): | | | |
| Professional discipline: | | | |
| Email: | Telephone: | | |
| Address: | | | Referral date: |

**PART B** *(for EYCT referrals)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PLEASE SELECT ✓ REASON FOR REFERRAL BELOW:** | | | | |
| Referral to support with nursery applications | | Area SENCO / Educational Psychologist ……..involvement | | |
| Toucan application | | Other – provide details below | | |
| **REASON FOR REFERRAL AND BACKGROUND INFORMATION** | | | | |
|  | | | | |
| **Is this referral also a Section 23 Notification?** *(For Healthcare professional referrers)* | | | | |
| Yes No | | | | |
| **PARENTAL CONSENT CHILDS NAME: DATE OF BIRTH:** | | | | |
| I consent to my child being referred to the Early Years Co-ordination Team. Information about my  child will be shared and discussed by the panel members, and decision will be made as to the most  appropriate services to become involved with my child's care.  f  I understand that the team may contact relevant services and obtain records in order to make a  decision about this referral.  c  I understand that the information in the referral form and actions taken will be held on a central  database.  ***\*VERBAL CONSENT CANNOT BE ACCEPTED***  Accepted written forms of consent are:   * Handwritten signatures * Handwritten electronic signatures (done via digital pen or finger on smart screens)   *\*Parent names typed as a signature also cannot be accepted* | | | | |
| Parent Signature |  | | Date |  |

**Please send completed to: Contact: 020 8836 8621 option 2**

**Early Years Co-ordination Team (EYCT)**

**Single Point of Access Team Email:** [**oxl-tr.childrenstherapies@nhs.net**](mailto:oxl-tr.childrenstherapies@nhs.net)

**Memorial Hospital Shooter’s Hill** *(add to subject line: “EYCT”)*

**London SE18 3RG**

Children should be referred into the Early Years Co-ordination Teamin a timely manner if they are already known to 3 or more supporting services across education and health or are likely to require 3 or more of the services connected to EYCT.

**TIP:** Please check the child you are referring into the team **lives in the Royal Borough of Greenwich** **or** has a **Greenwich general practitioner (GP).**

Early years settings should consider making a referral if they have implemented strategies, activities and advice already within their skill set and would clearly need to demonstrate what they have already done to support the child’s complex needs.

Evidence should be provided of targeted short-term support over and above that provided routinely as part of universal services and as part of the settings general practice in meeting the needs of all children in their setting, demonstrating that the setting has implemented strategies to support the child and the outcome of this support.

If the child already has any other agencies in the child’s existing support network (Speech and Language Therapist, Physiotherapist, Area SENCo, Educational Psychologist, Sensory Service teacher, ASD Outreach Team member etc.) every effort should be taken to include these reports with the referral.

When referring for Health Service input- the referrer should consider if the child’s parent(s)/ carer(s) are ready to engage in Health/therapy input to ensure the right families access support at the right time.

To support onward referrals from the EYCT meeting, panel members will need to ensure all the information is attached to the referral so that the relevant service triage team can make the decision based on their acceptance criteria.

Please note appendices will need to be completed as appropriate to support a referral to that service.

|  |  |
| --- | --- |
| **Please indicate the service(s) you would like the child to be referred to:** | |
| **Children’s Health Services**  **APPENDIX 1** - Health Information    **With option to request to refer on to:**  *Community Paediatrics*  *Speech and Language Therapy*  *Occupational Therapy*  *Physiotherapy* | **Education Services (Early Years Inclusion Team)**  **APPENDIX 2**  \*Referrals from a PVI Early Years setting and the child is not yet known to the Early Years Inclusion Team:  **please make sure APPENDIX 2 is completed, otherwise referral will be rejected and returned** |

**🞶🞶🞶 APPENDIX 1 🞶🞶🞶**

***HEALTH INFORMATION***

**\*PVI Early Years settings:** If child is already known to the ***Early Years Inclusion Team*** please tick

|  |  |
| --- | --- |
| **Please select 🗸 which children’s health service you would like to have child referred onto:** | |
|  | **Community Paediatrics** |
|  | **Speech and Language Therapy** |
|  | **Occupational Therapy** |
|  | **Physiotherapy** |
| What is the desired outcome as a result of this referral from the selected health service/s? | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Pregnancy and Birth** *(please select the most appropriate answer, if YES to any questions please provide details):* | | | |
|  | **Yes** | **No** | **Unknown** |
| Were there any problems during the pregnancy of child: |  |  |  |
| Were there any problems during the birth: |  |  |  |
| Were they born prematurely? |  |  |  |
| *If YES was selected for any of the above please write details here:* | | | |
| **Medical and Family Background** *(Please give any details as necessary):* | | | |
|  | **Yes** | **No** | **Unknown** |
| Are they generally well? |  |  |  |
| Are they on any regular medication? |  |  |  |
| Do they have any known allergies (including to medication)? |  |  |  |
| Have they had all their immunisations? |  |  |  |
| Have they had their hearing checked? |  |  |  |
| Have they had their eyesight checked? |  |  |  |
| Has the child/family ever been known to social care? |  |  |  |
| *Further details from the questions above:* | | | |

***COMMUNICATION***

No Communication concern / already supported – please move on to Sensory Skills Section

|  |  |
| --- | --- |
| **Please describe how the child communicates.** | |
| How does the child send a message to someone else when they want something?  What words/sentences does the child use?  What instructions does the child understand?  What non-verbal communication does the child use e.g. eye contact, pointing, facial expressions  How does the child interact with peers? | |
| **Please describe the child’s play skills and interests.** | |
|  | |
| **Are there any concerns regarding choking or gagging when eating and drinking?** | |
| If yes, please describe what happens.  Has the child had 3+ chest infections in the last 12 months? | |
| **What are the child’s communication targets that you are working on right now?** | |
|  | |
| **What strategies and activities have you tried already? What is in place to support the child/young person?** | |
| Intensive interaction/imitation |  |
| Give a reason to communicate….and wait |  |
| Attention group |  |
| Ready steady go games |  |
| Visual timetable |  |
| Now/next board |  |
| Objects of reference |  |
| Choice boards |  |
| Symbol exchange |  |
| Signing |  |
| Commenting, pausing and following child’s lead in play |  |
| Small talk vocabulary building games |  |
| Sentence building activities such as Colourful Semantics/Shape coding |  |
| Early Talk Boost |  |
| Other - Please describe: | |
| **What progress have you seen in the child as a result of the above?** | |
|  | |
| **What impact do the above concerns have on this child and their family? How do their difficulties affect them?** | |
|  | |
| **What specific support do you need from the SLT team to enable you to continue to support this child?** | |
|  | |
| **Any other information** | |
|  | |

***FINE MOTOR SKILLS***

*(coordination between child’s small muscles e.g those in hands, wrists and fingers in coordination with their eyes)*

No Fine Motor Skills concern / already supported – please move on to Sensory Skills Section

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please indicate the level of concern for this child from both the referrer and parent(s) perspectives, for each of the areas listed below.** | | | | | | | | |
|  | **No concern** | | **Mild concern** | | **Moderate concern** | | **Significant concern** | |
| Referrer | Parent | Referrer | Parent | Referrer | Parent | Referrer | Parent |
| Fine Motor /Hand skills |  |  |  |  |  |  |  |  |
| Dressing |  |  |  |  |  |  |  |  |
| Eating at Mealtimes |  |  |  |  |  |  |  |  |
| Using Cutlery |  |  |  |  |  |  |  |  |
| Using the toilet |  |  |  |  |  |  |  |  |
| Mark making/handwriting |  |  |  |  |  |  |  |  |
| Tool use – e.g. scissor skills |  |  |  |  |  |  |  |  |
| Seating |  |  |  |  |  |  |  |  |
| Attention & listening |  |  |  |  |  |  |  |  |

|  |
| --- |
| **What are the main functional concerns that impacts on the child’s daily life relating to their fine motor skills?** |
|  |
| **What strategies have already been tried to support the child with their fine motor skills?** |
|  |

***SENSORY SKILLS CONCERNS***

No significant Sensory Skills concern / already supported – please move on to Gross Motor Skills Section

|  |  |  |  |
| --- | --- | --- | --- |
| Please indicate if there are significant concerns with the following areas **of sensory processing that are impacting on the child’s participation in daily activities and /or development of skills** | | | |
|  | **Significant concern** | | **Please describe your concerns** |
| Referrer | Parent |
| Difficulty with textures, impacting on play and self-care tasks. |  |  |  |
| Frequently mouths non-food items, impacting safety |  |  |  |
| Seeks out all types of movement, which impacts concentration to tasks and learning. |  |  |  |
| Sensitivity to noise impacting participation in activities and accessing the community. |  |  |  |

|  |
| --- |
| **Any other information:** |
|  |

***GROSS MOTOR SKILLS***

*(Gross motor skills are for major body movements such as walking, maintaining balance, coordination and reaching)*

No Gross Motor Skills concern / already supported – skip below section

\*If your concern is regarding flat feet, bowlegs, knocked knees or in toeing gait there is no need to fill out the below

Please see this link for advice and reassurance that this is a normal variant of growth.

APCP links: <https://apcp.csp.org.uk/parent-leaflets>

|  |
| --- |
| **What is the main functional concern that impacts on the child’s daily life relating to gross motor skills?** |
| How are the child’s movement skills affected?  i.e. pain, falling, loss of skills, delay with attainment of gross motor skills |
| **What strategies have already been tried to support the child with their gross motor skills?** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Has this child received support from the Physiotherapy team previously? | | YES | NO |
| If YES, when? |  | | |
| Any other information: | | | |
|  | | | |

**🞶🞶🞶 APPENDIX 2 🞶🞶🞶**

***Education Services (Early Years Inclusion Team)***

**Status of childcare setting placement:**

Paid childcare  3- & 4-year free entitlement

2-year free placement  Mixture of those indicated above

Not currently attending an Early Years setting but due to start

|  |  |  |  |
| --- | --- | --- | --- |
| Setting: |  | Start date: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please indicate the level of concern for this child from both the setting and parent(s) perspectives, for each of the areas listed below. | | | | | | | | |
|  | **No concern** | | **Mild concern** | | **Moderate concern** | | **Significant concern** | |
| Setting | Parent | Setting | Parent | Setting | Parent | Setting | Parent |
| Communication and interaction |  |  |  |  |  |  |  |  |
| Cognition and learning |  |  |  |  |  |  |  |  |
| Sensory and / or physical |  |  |  |  |  |  |  |  |
| Behaviour, emotional and social development |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Reasons for requesting referral -** Please put as much information here as possible | |
| What has prompted you to make this referral today? |
|  |
| What strategies have you tried already? What is in place now to support the child? |
|  |
| How successful have these strategies been? |
|  |
| What specific help are you asking for from the Early Years Inclusion Team? |
|  |
| How do these difficulties affect the child and their family right now and what do you think the future impact will be if these difficulties are not addressed |
|  |
| Any other information: |
|  |

**LIST ATTACHED SUPPORTING INFORMATION/ EVIDENCE**

**(This may include some of the following) Please ✓**

|  |  |
| --- | --- |
| Transition / TAC meeting minutes / CIN meeting minutes |  |
| **Setting Information** | |
| Reports |  |
| Observation / EYFS tracking/ Summative Assessment |  |
| Targets / Personal Learning Plan targets- reviewed / current |  |
| One page profile / Profile |  |
| **Other:** | |