# Request for SEND Involvement

# Sensory Impairment Team

# Please use this form if you feel a child/young person has additional needs which their current level of provision is not addressing.

Please attach copies of any assessments, records or observations that will help us to assess the needs of this child/young person. If there is insufficient information attached we may not be able to process the request.

## Referral to:

**Please indicate which sensory team you require.**

### Vision Hearing Multi-sensory

## Details of child or young person

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Pupil Surname :** | | | | |
| **Pupil Forename :** | | | **Pupil UPN :** | |
| **Date of Birth :** | | | **Year Group :** | **Gender :** |
| **Parent/Carer :** | | | | |
| **Home Address :** | | | | |
| **Telephone :** | | | | |
| **Parental e-mail (if available) :** | | | | |
| **School :** | | | | |
| **School Tel No :** | | | | |
| **School e-mail :** | | | | |
| **SENCo :** | | **Class Teacher :** | | |
| **Who has parental responsibility?** | | **Is pupil in CLA system?** Yes / No | | |
| **Is pupil in receipt of free school meals?**  Yes / No | **Does the pupil attract Pupil Premium?**  Yes / No | | | **Is pupil EAL?**  Yes / No |
| **Are there any additional (not VI/HI/MSI) medical conditions that staff working with this pupil need to be aware of?** Yes / No  Please provide details as appropriate: | | | | |
| **Please indicate the pupil's status regarding the SEN Code of Practice:** SEN Support / EHCP | | | | |
| **Has the pupil been diagnosed with a hearing, vision or multi-sensory impairment by a consultant?**  Diagnosis:  Name of Consultant / Hospital: | | | | |
| **Please indicate services which have been involved with the pupil:**  LST / CCD / PD / MET / SALT / EP / Early Intervention / Stronger Families / CAMHS / School Health / PRU/ Occupational Therapist / GRT / Physiotherapist / Other (*please specify)* | | | | |

## Progress and attainment in learning

|  |  |
| --- | --- |
| **EYFS Learning goals** | **EYFS Profile/Achievement** |
| Personal, Social and Emotional development |  |
| Physical Development |  |
| Communication and Language |  |
| Literacy |  |
| Mathematics |  |
| Understanding of the World |  |
| Expressive Arts and Design |  |

**Key Stage 1-2 (Please rate each subject using the scale)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Reading | Writing | Maths |
| Significantly below ARE |  |  |  |
| Slightly below ARE |  |  |  |
| In line with ARE |  |  |  |
| Slightly Above ARE |  |  |  |
| Significantly above ARE |  |  |  |

**Key Stage 3-4. Student currently working at:**

|  |  |  |
| --- | --- | --- |
| **English** | **Maths** | **Science** |
|  |  |  |

## Supporting information

In order to process your request please attach copies of the following reports where available:

* Consultant/hospital letter
* Pupil's current IEP / Provision Map / Passport
* Most recent SATs results and Teacher Assessment Levels
* Any other reports which may be relevant to support the Referral

In all cases, parental consent must be obtained prior to Sensory Impairment Team involvement. It is the setting's responsibility to obtain this. Please ensure that this has been done before returning this form – we are unable to accept referrals without parental consent.

### Parental / Carer Consent

Parents/carers have given permission for SI Team involvement

Yes ⬜ No ⬜

Parents/carers have read through all information on this form and consent to it being shared with the SI Team

Yes ⬜ No ⬜

Parents/carers have consented to the Specialist Teacher sharing appropriate information with other professionals within Education Services, Children’s Services, Audiology/Ophthalmology and Child Heath

Yes ⬜ No ⬜

Parents/carers have consented to the Specialist Teacher contacting the relevant consultant/specialist at hospital to gain information on the child’s diagnosis and any assessments undertaken there which will inform levels of provision and support

Yes ⬜ No ⬜

Parent/carer signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person requesting involvement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you require help completing this form please contact the Sensory Impairment Team:

Tel: 01905 843 975

Email: [SensoryImpairment@worcschildrenfirst.org.uk](mailto:SensoryImpairment@worcschildrenfirst.org.uk)

This form should be returned to the Sensory Impairment Team, either through the Worcestershire County Council Children’s Services Portal or by post to:

Sensory Impairment Team Lead

Worcestershire Children First

County Hall, Spetchley Road, Worcester, WR5 2NP

The Specialist Teacher will be in contact within 15 working days upon receipt of your request for involvement.