

Gateshead Pre School Education, Health and Care (EHC) Referral Panel

It is expected that this referral will generally come from a TAF meeting and will include information from the education and health services.

PLEASE complete the forms below and return with the completed parental consent form and all relevant documents (listed in the checklist) to:

Christina Birkinshaw, Administration Officer
Dryden Centre, Evistones Road, Gateshead NE9 5UR

OR email: christinabirkinshaw@gateshead.gov.uk or
preschoolEHCrefferralpanel@gateshead.gcsx.gov.uk

If you have any queries, contact the team on 0191 433 8734.

Child's details

Child's name			Date of birth
Address			
Postcode			
Person with parental responsibility			
Relationship to child			Contact number
Child's ethnicity	Home Language(s)		
Child's NHS number (if known)			
Unique pupil number (if known)			
Is GP/health visitor aware of this referral?	YES	NO	
Children Act (1989) status (if looked after)			
Is the Area SENCo aware of this referral?	YES	NO	
If yes please state who			
Date of next TAF meeting (if appropriate)			
GP name and surgery details	Health visitor name and contact details		

Education/childcare setting details (if applicable)

Setting name

Type of provision

Address

Postcode

Telephone number

Key worker

Date child started

Reason for referral and diagnosis if known *(this section must be completed)*

Current level of development in primary areas

To be completed by education provider only. Please tick relevant box for each sub-heading.

Personal, Social and Emotional Development

Making relationships

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

Self-confidence and self-awareness

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

Managing feelings and behaviour

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

Communication and Language

Listening and attention

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

Understanding

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

Speaking

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

Physical Development

Moving and handling

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

Health and self-care

Birth – 11 months	16 – 26 months	22 – 36 months
8 – 20 months	22 – 36 months	30 – 50 months

What interventions have already been put in place?

To be completed by all professionals.

Please list all professionals involved

Please comment on the following areas

Brief details of birth history (pregnancy, labour and delivery)

Birth weight

Gestation

Significant health issues and investigations

Significant family history information

Vision and hearing

Social communication

Understanding

Speaking

Eating/drinking

Nutrition

Sleeping

Toileting

Self-help skills

Medication

Behaviour and social skills

Play skills

Gross motor skills (sitting/crawling/walking)

Fine motor skills

Please attach individual programme details and specific targets, observational notes, developmental profiles or other appropriate evidence to support the above.

Any other comments/supplementary information

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To comply with GDPR legislation please make sure you have signed parent/carer permission to share information.

Parental Consent Form

Name(s) of Parents(s)/Person(s) with Parental Responsibility

Person 1

Title Forename Surname

Telephone number (home) Mobile

Address

Postcode

Relationship to child

Person 2

Title Forename Surname

Telephone number (home) Mobile

Address

Postcode

Relationship to child

I give permission for this referral to the Early Years Multi-Agency Referral Panel

I agree to work in partnership with member(s) of the team

I understand the information recorded on this form and that it will be stored and used only for the purpose of providing service to myself, or a child for whom I have parental responsibility

**As a result of the panel we may share information with the following agencies.
Please tick to say which agencies the information can be shared with.**

Child Development Team (Paediatrician, Occupational Therapy, Speech and Language Team,
Specialist Health Visitor, Physiotherapist, Community Nursery Nurse)

Children with Disabilities Team

Early Years (0-4) Assessment and Intervention Team

Area SENCo

Low Incidence Needs Team

Do you have any specific concerns about your child that you wish to tell us about?

What are the main outcomes you hope our intervention will achieve? For example, improve your child's independence, confidence?

Signed

Name

Date

Referrer's Details

Referred by

Agency/setting

Position (SENCo, Health visitor, etc.)

Telephone number

Email

Address

Postcode

Checklist

Documents you must include with this referral.

NOTE: the panel will not consider the application if ALL relevant documents and signatures are not included.

A copy of the CAF (essential)

A copy of any health assessments (eg schedule of growing skills, ASQ, ASQse (if applicable))

A copy of the child's 2-year old check EYFS

A copy of the child's current IEP/Action Plan (if in nursery/childcare setting)

Copies of reports from any other professionals involved with this child

Signed parental consent form