Gateshead Council | Gateshead Health NHS Foundation Trust | Harrogate and District NHS Foundation Trust | educationGateshead raising achievement for all

Gateshead 0-4 Referral

Guidance for Referrers

- This is the referral form for Gateshead children aged 0-4 years with suspected special educational needs and disabilities. The referral will be reviewed and discussed at fortnightly panel meetings (term time only) which are attended by professionals from teams including **SALT, Portage, the Autism Assessment Team, the Child Development Team and LINT**.
- All professional contact information must be completed **IN FULL** and sections marked with a * **MUST** be completed.
- It is the responsibility of the referrer to keep us updated about any relevant changes (contact numbers, address, setting, etc.) once this form has been submitted.
- Please see supplementary booklet for further guidance on completing this referral form and the criteria set out for acceptance into each service.

Checklist

Supporting documents you MUST include with this referral, either:

- ☐ A copy of any health assessments e.g. schedule of growing skills, ASQ, ASQse (health visitor referrals)
- ☐ A copy of the EYFS progress check for children between 2-3 years (nursery referrals)

AND

- ☐ Copies of reports from any other professionals involved with this child, including reports/clinic letters from Health

Signatures

- ☐ Please ensure that parent/carer consent has been completed in full.
- ☐ ALL families should receive a copy of the information booklet about the 0-4 panel meeting prior to obtaining consent
- ☐ Please ensure this referral has been shared between nursery and the child's Health Visitor (if attending nursery)

NOTE: The referral will not be considered unless **ALL** relevant documents and signatures are included.

Please complete and return to 0-4referral@gateshead.gov.uk using secure email. Receipt of referrals will be acknowledged by secure email to the referrer. If you have not received an acknowledgment within two weeks, please contact the team on 0191 433 8734.

Child's details

Child's name

Date of birth | Gender | Ethnicity

Address | Postcode

Child's NHS number (if known)

UPN (if attending Nursery)

GP name and surgery*

Home language

Interpreter needed? Yes ☐ No ☐

Accessibility: If you would like this information in a different format such as Braille, large print, or in a different language please contact us.

Safeguarding concerns

Child in care? Current ☐ Previous ☐ No ☐

If current social care involvement: Early Help ☐ Child in Need ☐ Child Protection Plan ☐

Special Guardianship? Yes ☐ No ☐

Adopted Yes ☐ No ☐

If CAF has been completed, date of next TAF meeting

Any lone working concerns? Yes ☐ No ☐

People with parental responsibility

1. Name

Relationship to child | Contact number

Address (If different to child)

Email address

2. Name

Relationship to child | Contact number

Address (if different to child)

Email address

Health Visitor details

Name

Contact Tel. No. | Email

☐ **The nursery/childcare setting have been informed of this referral** **Date**

Nursery/childcare setting details (if applicable)

Setting Name

Address | Postcode

Contact Tel. No. | Email

Child's Start Date | Current attendance **(% of possible attendance)**

Staff contact name & position

Intended nursery/school (if not currently in education)

☐ **The child's Health Visitor has been informed of this referral** **Date**

Referrer's details

Name of Referrer

Position (SENCo, Health Visitor, etc.)

Telephone number

Email

Please list all professionals involved, including email address and phone number.

Reason for Referral

What do you hope the outcome of this referral will lead to? ***(Please select all that apply)***

- ☐ Autism Assessment
- ☐ Speech and Language Therapy
- ☐ Portage
- ☐ LINT
- ☐ Child Development Team Assessment

Other - additional information to identify support:

What are the current concerns or unusual features in the child's development and learning?

Overview of each area using the Gateshead SEN Thresholds Documents.

Explain both achievements and difficulties. (If meeting milestones give an overview of what they have achieved). Describe impact of delays/gaps in learning. If regression has been observed state clearly what they could do and now cannot.

Speech and Language

Full description of a child's communication methods, understanding and spoken language is essential for referrals for SALT input.

(For example how does the child let you know what they want/need? What spoken language do they use? Can they understand and follow simple commands? Any regression in speech and language development?)

Social Communication and Interaction

(For example does the child respond to their name? How does the child interact with those around them? Do they have any friends? Can they maintain eye contact and use gestures like pointing or waving?)

Play, Cognition and Learning

(For example how long can they focus on an activity? What do they enjoy doing? Any imaginary play? Can they follow the lead of others during play?)

Gross and Fine Motor

(For example describe the child's current motor skills development.)

Vision and Hearing

(For example any concerns with vision or hearing? Any previous vision or hearing tests?)

Sensory Needs and Behaviour

(For example any sensory seeking or repetitive behaviours? How do they cope with change? Any specific routines? Has OT referral been submitted?)

Eating, Sleeping, Toileting and Bathing

(For example any significant challenges in these areas? Describe their self-care skills.)

ASQ Summary Information

Date of last assessment:

Please provide details:

Area	Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	24.02			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gross Motor	28.01			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fine Motor	18.42			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problem-solving	27.62			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Personal/Social	25.31			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Early Years SEND Thresholds

Date of last assessment:

Please provide details:

Early Years SEND Threshold Areas	Primary Area(s) of need - Threshold Level:
Cognition and Learning	
Communication and Interaction	
Social, Emotional and Mental Health	
Sensory and/or Physical and Medical Needs	

What has been done so far to support the child and how has this made a difference?

At home

(What EYP intervention has been tried and what is the response?)

At nursery/childcare setting (if applicable)

(What strategies have been tried and what was the response?)

What is not working?

(For example explain any regression, map the journey of the development with timescales, any non-engagement from parents or if current intervention has not had any impact.)

What are the biggest challenges for the family on a daily basis?

What support do you think will benefit the child and give them the best opportunity to meet potential?

Please comment on the following areas, if relevant to the referral.

Include all relevant information available from the Health Records.

Brief details of birth history (pregnancy, delivery, birth weight and gestation. Require special care?)

Any significant health concerns or diagnoses for the child? Are they awaiting / undergoing any physical or medical assessments?

Any history of learning or developmental difficulties in close family members?

Have you as the referrer, other involved professionals or the child's family considered if the child might have a specific developmental diagnosis? For example, Autism, Global Developmental Impairment (previously known as Global Developmental Delay), ADHD, other diagnosis.

Please note that health services accessed through this referral are NOT able to assess for ADHD.

Supplementary Information

Is there any other relevant information NOT included in the form previously?

Gateshead 0-4 Referral

Parent/Carer Consent

The information provided on this form will be processed and shared in accordance with the Data Protection Act and the General Data Protection Regulations (2018). The agencies who attend the 0-4 Referral meetings are listed below:

- **The Growing Healthy Gateshead 0-19 Service (NHS)**
- **Child Development Team and Autism Assessment Team (NHS) – represented by consultant paediatrician**
- **Speech and Language therapist**
- **Portage (Education)**
- **LINT**
- **Social Care**

The information within this referral will be shared with all attendees in order to decide on the most appropriate support for your child.

Please tell us about your specific concerns*

Please give details of what your child is good at and what you or others enjoy about them*

What difference do you hope the referral will make for your child?*

Continued on next page

In order to undertake a comprehensive assessment of your child's needs, relevant information may be gathered from other health services, social care and education. If you do not consent to information sharing between these agencies, we may not be able to complete the required assessments.

- ☐ I/we give permission for this referral to be submitted to the 0-4 Referral Meeting. *
- ☐ I/we give permission for the following services to be involved (if appropriate for my child)
  - ☐ Portage
  - ☐ SALT
  - ☐ Autism assessment Team
  - ☐ Child Development team
- ☐ I / we give permission for relevant information to be shared between education, health and social care for the purposes of assessing my child's needs
- ☐ I/we understand that the information recorded on this form will be securely stored and used only for the purpose of providing a service to a child for whom I/we have parental responsibility, including future discussions id necessary*
- ☐ I/we have seen the parent/carer information leaflet. *

Parent/Carer

Name _____ Relationship to child _____

Signature* _____ Date _____