

# Gateshead Pre-School (0-4) Referral Panel

**Please read the following before completing the form for Pre-school Referral Panel .**

- This is the referral form for Gateshead pre-school children with special educational needs and disabilities
- The information will be discussed at fortnightly meetings attended by Professionals from teams within Education, Health and Social Care
- All professional contact information must be completed **IN FULL**
- All required information **MUST** be provided

**If possible, please return electronically 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.

**Email:** [PreSchoolEHCTReferralPanel@Gateshead.Gov.UK](mailto:PreSchoolEHCTReferralPanel@Gateshead.Gov.UK)

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

## Child's details

Child's name

Date of birth

Address

Postcode

---

## 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

---

Child's NHS number *(if known)*

GP name and surgery

Unique pupil number *(if known)*

Looked After Child?      Yes      no

If CAF has been completed, date of next TAF meeting

## Referrer's details

Referred by

Agency/setting

Position (SENCo, Health Visitor, etc.)

Telephone number

Email

Address

## Education/childcare setting details (if applicable)

Setting name

Type of provision

Address

Postcode

Telephone number

Email

Name of Area SENCo

Date of most recent contact

**Strengths and needs in the areas of Personal, Social and Emotional Development, Communication and Language, Physical skills.**

# 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

## Development and Interventions

Please summarise development over time, interventions that have been put in place and the impact they have had. For example, summary of ASQ's, focus of Early Years Practitioner.

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

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

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

Any significant health issues and investigations

Any significant family history information

Vision and hearing

**Any other comments/supplementary information. This should include information about support for other members of the family and any existing lone working procedures.**

# Pre-school (0-4) Referral

## Parental Consent Form

To comply with GPDR legislation please make sure you have seen the referral form and any additional documents and give informed written consent to share information with all services who attend the Panel.

Please tick to confirm the information on this referral can be shared with these services. Consent must be given to share with all services who attend Panel.

Early Years (0-4) Assessment and Intervention Team

Area SENCo

Low Incidence Needs Team (Vision, Hearing and Multi-Sensory Impairments)

Educational Psychology Service

The Growing Healthy Gateshead 0-19 service

Early Years Childcare service

Children with Disabilities Team

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

---

**Please tell us about your specific concerns**

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

Home language:

Do you need an Interpreter?

Yes

No

**I/we give permission for this referral to the Pre-school (0-4) Referral Panel.**

**I/we 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.**

**I/we have seen the parent/carer information leaflet**

### Person 1

Name

Relationship to child

Signature

Date

### Person 2

Name

Relationship to child

Signature

Date

## 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. Parental consent must have been gained to share these additional documents.

A copy of the CAF (if applicable)

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

A copy of the EYFS progress check for children between two and three years (if applicable)

Any written record of the child's progress and next steps

Copies of reports from any other professionals involved with this child

Signed parental consent form (essential)