# Referral form for Low Incidence Team and Sensory Service

**Please complete this form, print and obtain required signatures before scanning and submitting this document to:** SensoryAndPhysicalNeeds@bradford.gov.uk

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| **Visual Impairment****VI** | **Hearing Impairment****HI** | **Multi- Sensory Impairment** | **Physical & Medical****P&M** |
| [ ]  | [ ]  | [ ]  | [ ]  |

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| **School/Setting Information** |
| School/Setting: |  |
| Name of person referring: |  | Date of referral: |  |
| Position: |  |
| Contact Email: |  |
| Contact Telephone: |  |

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| **Pupil details** |
| **First Names:**   |   | **Surname:**  |   |
| **Date of Birth:**  |   | **Gender:**  |   |
| **Home Language:** |   | **Ethnicity:** |   |
| **Primary need:** |   | **Any other disabilities/needs:** |   |

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| Parent/Carer’s  | Title:  First name: Surname:  | Parent/Carer’s  | Title:  First name: Surname:  |
| Parent/Carer’s Address: |  | Parent/Carer’s Address: |  |
| Phone No: |  | Phone No: |  |
| Relationship to child/young person: |  | Relationship to child/young person: |  |
| Residence of child/young person?  | Yes [ ] No [ ]  | Residence of child/young person?  | Yes [ ] No [ ]  |
| Parental responsibility?  | Yes [ ] No [ ]  | Parental responsibility?  | Yes [ ] No [ ]  |
| **Interpreter needed:** | Yes [ ] No [ ]  | Interpreter needed: | Yes [ ] No [ ]  |

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| **Does the child/young person have:** |
| Medical conditions/ diagnoses?  |  | Date: |  |
| My Support Plan? | Yes [ ]  | No [ ]  |
| Education Health and Care Plan? | Yes [ ]  | No [ ]  |
| Early Help | Yes [ ]  | No [ ]  |
| Pupil Premium | Yes [ ]  | No [ ]  |
| Is EYIF in place / % | Yes [ ]  | % | No [ ]  |
| Is there a child protection plan | Yes [ ]  | No [ ]  | Child Looked After | Yes [ ]  | No [ ]  |

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| **Are there any other agencies involved/supporting this pupil? E.g. Ophthalmologist, Audiologist, Paediatrician, EPs, SaLT etc.** |
| Name of Professional | Agency |
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| **What levels/AREs is this pupil currently working at?****For Early Years/PVI include Early Support Developmental Journal Levels** |
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| **What is the reason for this referral?** |
| Please provide as much information as possible. Please include a description of the desired outcomes from the involvement of the Low Incidence Team and Sensory Service. |

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| **Describe the needs of the child/strategies that have already been used to support the child/young person prior to the referral.** |
| It is very helpful to know what has already been done, or is currently in place, to help the child / young person before making this referral. Please provide as much information as possible.Please provide copies of reports from other professionals particularly with regard to diagnosis details e.g. visual assessment results. |

**Role of the Low Incidence Team and Sensory Service**

Support from the Low Incidence Team will include advice and visits to the home/setting/school by a range of qualified Specialist Teachers and professionals to advise you on your child’s physical and medical difficulties and on how you can help them.

Due to the nature of working with children and young people who have low incidence needs there may be occasions where direct physical contact is required in order to meet needs such as management of equipment, appropriate manual handling and communication strategies.

As officers of Bradford Council we have a responsibility to report any safeguarding concerns around the children we work with. If we feel it will help to support your child we will call a meeting with you and relevant professionals to discuss the best way forward.

**Parent/Carer agreement for the involvement of the Low Incidence Team and Sensory service**

I give consent for information about the child/young person in my care to be shared with staff in the Low Incidence Team and Sensory Service including reports from health, education and social care.

I give consent for information about the child/young person in my care to be shared with other services in the Council as necessary.

I give consent for members of the Low Incidence Team to observe and work with the child/young person in my care.

I give consent for information to be shared with other agencies and professionals who are involved with the child/young person in my care.

Under the General Data Protection Regulation (GDPR), I have the right to request a copy of the information the Council holds about me and my child. For more information I can contact the Data Protection Officer.

I give consent for stories/photographs/digital images of the child/young person in my care to be used for the following purposes:

Internal publications 🞏

External publications 🞏

Training 🞏

Information leaflets/displays 🞏

Making resources for the child/young person in my care 🞏

Assessment 🞏

Parent/carer name: …………………………………………………………………………………………………..

Parent/carer signature: ……………………………………………….. Date**:** …………………………………….

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| --- | --- | --- | --- |
| **School signature****Print name** |  | **Signature** |  |

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**Please return this form by secure email to:** SensoryAndPhysicalNeeds@bradford.gov.uk

**General Data Protection Regulations (GDPR)** - <https://www.bradford.gov.uk/privacy-notice/>