**Please complete form fully and send with appropriate supporting evidence via 0-5 Anycomms. This is the preferred method. If no access to Anycomms, please send password protected to** **0-5SEND.SupportService@sheffield.gov.uk**

|  |
| --- |
| Child’s Details |
| Forename |  | Surname |  |
| D.O.B  | Click here to enter a date. | Gender  | Female [ ]  Male [ ]   |
| Address |  | Postcode |  |
| TelephoneNumber |  |
| Are they a Child Looked After (CLA) Yes [ ]  No [ ]  |
| Primary Parent/Carer Details |
| Relationship to child | Choose an item. | Parental ResponsibilityYes [ ]  No [ ]  |
| Forename |  | Surname |  |
| Address(If different from above) |  | Postcode |  |
| Telephone Number |  |
| Email address: |
| Setting Details |
| Please tick if no setting currently attended [ ]  |
| Name of setting |  | Start date at setting | Click here to enter a date. |
| Days/Hours attended | Monday  | [ ]   | from ………………. to …………………... |
| Tuesday | [ ]   | from ………………. to …………………... |
| Wednesday  | [ ]   | from ………………. to …………………... |
| Thursday | [ ]  | from ………………. to …………………... |
| Friday | [ ]   | from ………………. to …………………... |
| Referrer Details |
| Name of Referrer |  |
| Job Title/Role |  |
| Address |  | Postcode |  |
| Telephone Number |  |
| Email address: |
| Reason for Referral |
| Area(s) of Concern | [ ]  Social Communication Differences[ ]  Speech, Language and Communication Needs[ ]  Social, Emotional and Mental Health [ ]  Profound and Multiple Learning Difficulty[ ]  Cognition and Learning[ ]  Physical/Medical [ ]  Sensory |
| Early Years Sheffield Support Grid Levels (SSG) please only level relevant areas. [new-early-years-ssge-may-2025.pdf](https://www.sheffielddirectory.org.uk/media/km2i2su3/new-early-years-ssge-may-2025.pdf) |
| Please use the EY SSG (link above) to ensure you assess and indicate levels of need for the child. Evidence provided should support the given level of need. |
| Communication & Interaction | Speech and Language (1A) | Choose an item. | Sensory and/orPhysical | Visual Impairment (4A) | Choose an item. |
| Social Communication (1B) | Choose an item. | Deaf (4B) | Choose an item. |
| Speech and Stammering (1C) | Choose an item. | Physical (4C) | Choose an item. |
| Cognition & Learning | Learning (2)  | Choose an item. | Medical (4D) | Choose an item. |
| Social, Emotional & Mental Health  | Emotional Regulation (3) | Choose an item. | Sensory (4E) | Choose an item. |
| Professionals and Agencies Involved please include names and send copies of reports if available |
| **Professionals**[ ]  Consultant Paediatrician[ ]  Speech and Language Therapist[ ]  Physiotherapist[ ]  Occupational Therapist[ ]  Health Visiting Team[ ]  Hearing Support Service[ ]  Vision Support Service[ ]  Family Intervention Service (FIS)[ ]  Social Worker[ ]  School Readiness[ ]  Early Years Inclusion Teacher Consultation | **Details**  |
| Referrals Made please include dates if known |
| [ ]  Community Paediatrics Date:[ ]  Speech and Language Therapy Date:[ ]  Ryegate – Social Communication Clinic/Autism Assessment Date:[ ]  Physiotherapy Team Date:[ ]  Occupational Therapy Team Date:[ ]  Family Intervention Service (FIS) Date: |
| What are the child’s strengths and interests? What is working well? |
|  |
| What are the main concerns regarding the child? What are you worried about? |
|  |
| What has already been implemented for the child? Please list any strategies, interventions or support already trialled/in place. |
|  |
| Any additional information  |
|  |
| Consent \*Please note, a ‘wet’ signature must be obtained before we can begin any work\* |
| This referral has been fully discussed with me and I consent to my child being referred to the 0-5 SEND Support Service. I give my consent for the 0-5 SEND Support Service to disclose to and receive from Education, Social Care and Health Services, personal information about my child as part of the services delivered.**Signature of Parent/Carer ………………………………………………………………….. Date:** |
| I have discussed all of the information in this referral with the parent/carer. **Settings only:** I understand it is the responsibility of the setting to inform parents of visit dates and share all reports. **Signature of Referrer ……………………………………………………………………. Date:** |
| Supporting Evidence please indicate what supporting evidence you are including along with this referral.* At least TWO pieces of supporting evidence MUST be included.
* If the referral is being made by setting, a minimum of TWO cycles of Assess, Plan, Do, Review MUST be provided
 |
| [ ]  Evidence of Graduated Response – Assess, Plan, Do, Review[ ]  Minutes of meetings with parents[ ]  Minutes of meetings with professionals[ ]  0-5 SEND Consultation Record[ ]  Clinic reports[ ]  Additional reports from Professionals/Medical Professionals[ ] Other – please indicate …………………………………………………………………………………….**Please note – if supporting evidence is not received, the referral will not be processed.** |
| Checklist – any referrals that are incomplete or are missing information will not be processed. |
| [ ]  Contact details of parents including email address[ ]  Parent/Carer ‘wet’ signature[ ]  Sheffield Support Grid Levels [ ]  Supporting Information[ ]  All sections of referral form complete where possible |