**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**](mailto:0-5SEND.SupportService@sheffield.gov.uk)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Details | | | | | | | | | | | | | | | |
| Forename |  | | | | | | | Surname | | | |  | | | |
| D.O.B | Click here to enter a date. | | | | | | | Gender | | | | Female  Male | | | |
| Address |  | | | | | | | Postcode | | | |  | | | |
| Telephone  Number | | | |  | | | |
| Are they a Child Looked After (CLA) Yes  No | | | | | | | | | | | | | | | |
| Primary Parent/Carer Details | | | | | | | | | | | | | | | |
| Relationship to child | | | Choose an item. | | | | | | | | | Parental Responsibility  Yes  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/or  Physical | | 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 | | | | | | | | | | | | | | | |