



HILLINGDON
LONDON

SEND Advisory Service referral form

The SEND Advisory Service is a multi-disciplinary service that has brought together the support previously provided by the Inclusion team, the Sensory Intervention team and the SEND Key Working component of the Early Support team.

All sections marked * must be completed.

Section 1: Child/Young Person Information

Primary reason for referral*			
<input type="checkbox"/> Communication and interaction	<input type="checkbox"/> Cognition and Learning	<input type="checkbox"/> Physical needs	<input type="checkbox"/> Social Emotional Mental Health
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Other (please specify)	

First name of child/young person*	
Surname of child/young person*	
Also known as	
Unique Pupil Number (UPN)*	
Date of birth*	
Borough and residence of child/young person*	
Parent/Carer/Guardian full name*	
Parent/Carer/Guardian telephone number and email address*	

Home address if different from child/young person	
Parent/Carer/Guardian full name*	
Parent/Carer/Guardian telephone number and email address*	
Home address if different from child/young person	
Who has parental responsibility?*	
Who does the child usually reside with?*	
Siblings information, name, age, DOB, school attended if known	
Language spoken at home	
Are there any communication, interpreter or signer needs for the family?*	
Any other considerations regarding family background	

Ethnicity (Please select the relevant category)*		
<input type="checkbox"/> White English	<input type="checkbox"/> White Irish	<input type="checkbox"/> Any other White background
<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	<input type="checkbox"/> Any other Black background
<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Bangladeshi
<input type="checkbox"/> White and Black Caribbean	<input type="checkbox"/> White and Black African	<input type="checkbox"/> White and Asian
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Any other mixed/multiple ethnic Background
<input type="checkbox"/> Any other Ethnic Group	<input type="checkbox"/> Not given	<input type="checkbox"/> If other, please state

Section 2: Other professionals/agencies involved with the child/young person*

Role	Name of professional and/or team details	Telephone/Email contact details	Date of involvement if known
GP			
Social Care (please supply details if applicable)			
Please list any other relevant professionals, for example Occupational Therapist, Health Visitor, etc			

Please attach any relevant current documents or reports from involved professionals that may assist with this referral.

Section 3: Referrer details

Name of referrer/person completing form*	
Role (e.g. parent, teacher, professional)*	
Email address*	
Telephone number*	

Reasons for referral* (This should include areas of need and the impact of the difficulties, and details of any relevant clinical diagnosis)

Any other family/home information or concerns

If this referral is from Audiology or Ophthalmology please move to section 6

Section 4: Education/Provision

Name and address of the child/young person's setting, school, college or education provider*	
Telephone number*	
Email address*	

Please describe the strengths and any further information about the difficulties of the child/young person in accessing the curriculum

Has a SEND Team Around the Child/Young Person or Family taken place?*
YES / NO / Unknown (Delete as appropriate)

If YES, please include any information that is relevant to this referral

Does the child/young person have a My Support Plan in place?*
YES / NO (Delete as appropriate)

If YES, please include with this referral. If NO, please supply relevant IEP or alternative document outlining support and strategies in place.

Does the child/young person have an Education Health Care Plan (EHCP)?*
YES / NO (Delete as appropriate)

Section 5: Views of relevant people involved

Child or young person's view on referral

Parent/Carer's view on referral



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Section 6: Consent to Referral

Has this referral been explained to the child/young person and their parents/carers/guardians?*
YES / NO (Delete as appropriate)

Has the child/young person and/or their parents/carers/guardians given consent for this referral?*
YES / NO (Delete as appropriate)

Parent/Young person’s consent for information storage and information sharing*

I consent to the London Borough of Hillingdon, in its capacity of Data Controller, processing the information on this form (“personal data”) for the purpose of providing services to:

- Me** (for young people over the age of 16)
- Child or young person for whom I am a parent**
- Child or young person for whom I am a carer or guardian**

By ticking this box, I consent to information on this form being shared between the services listed below. I consent that information can be shared between these agencies for the purpose of carrying out assessments and future fact finding for the aim of giving the best support possible for the named child or young person on this form.

By signing the form, I consent to the London Borough of Hillingdon collecting and processing my personal data (and/or that of my child or young person) for the purposes set out. I understand that I have the right to withdraw my consent at any time by contacting sasinclusion@hillington.gov.uk

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3.	4.

Signed (Young		Na e		Date	
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SEND Advisory Service Referral Form

person or parent)					
Signed (Referrer)		Name		Date	

Privacy notice: The London Borough of Hillingdon (LBH) is the data controller in regards to any personal data you submit using this form. LBH processes personal data in line with its obligations under data protection legislation. For more information on how LBH will process your data please visit www.hillingdon.gov.uk/privacy

All sections marked * must be completed.

Please return the fully completed form to:
SEND Advisory Service,
4E/02 Civic Centre,
High Street,
Uxbridge UB8 1UW

Tel: 01895 250111

Email:

Early Years and Schools: sasinclusion@hillingdon.gov.uk

Key Working: saskeywork@hillingdon.gov.uk

Sensory Impairment: sassensory@hillingdon.gov.uk

If emailing this form, please ensure you use a secure email address, keeping in mind the General Data Protection Regulations. Please use the subject title 'Send Advisory Service Referral' and attach this form to the email.