LINCOLNSHIRE COUNTY PORTAGE SERVICE
REFERRAL FORM

Child's Name: **DOB:** **Address:**	**Name of Parent / Carer:** **Email Address:** *Please provide where possible* **Mobile No:**

Health Visitor **Tel No:**	**Home Language:**

Names of current professionals and details of involvement/intervention:
Speech and Language Therapist (SALT):
Physiotherapist:
Occupational Therapist:
Community Paediatrician:
ESCO:
KIDS:
SEST:
Social Worker
TAC:
CIN:
Child Protection:

Reasons for referral and description of difficulties: Please note : to be eligible for Portage a child would be identified as having significant delay in two or more prime areas of their development
Please give details on the following areas:
Communication and Interaction:
Physical/Sensory:
Social & Emotional:
Cognition/Play/Learning:
Self Care:

Name of setting/group child attends and for how many hours.
Please provide information on current targets and how these needs are met with the support from the relevant agencies involved.

Please note: A child who is accessing EY provision and are having their educational needs met, regardless of the hours they attend **MAY NOT** meet the criteria for Portage Home Visiting. The outcome of an initial visit will be agreed with the Portage Service Lead, and the referrer and parent/carer notified.

Referred by: **Address:** **Email:** *Please provide* **Tel no:** **Signature:** **Date:**	Please return this form, with parental permission, to: Mrs V Gross Portage EY SEND Practitioner Boston Endeavour Academy Kitwood Road Boston Lincolnshire PE21 OPX. Tel 07502970926 Victoria.gross@bea-cit.co.uk