



LINCOLNSHIRE COUNTY PORTAGE SERVICE
REFERRAL FORM



<p>Child's Name:</p> <p>DOB:</p> <p>Address:</p>	<p>Name of Parent / Carer:</p> <p>Email Address: <i>Please provide where possible</i></p> <p>Mobile No:</p>
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<p>Health Visitor</p> <p>Tel No:</p>	<p>Home Language:</p>
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Names of current professionals and details of involvement/intervention:

Speech and Language Therapist (SALT):

Physiotherapist:

Occupational Therapist:

Community Paediatrician:

ESCO:

KIDS:

SEST:

Other:

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.**

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