September 2021

Warwickshire SEND 0-5
Single Point of Access (SPA) Referral Form

Please complete this form as fully as possible to avoid delays.
When completed please return to your nearest base:

Building 1
Saltisford Office Park
Warwick
CV34 4UL
Tel: 01926 413737 option 6

Kings House,
King St,
Bedworth
CV12 8LL
Tel: 01926 413777

Or email to: **idsteachingandlearning@warwickshire.gov.uk**

Requesting Guidance from:-

0-5, Teaching and Learning (including Portage at home, Specialist Teaching and SEND childcare) ☐

Warwickshire Preschool Autism Service (previously known as CDS) ☐

Other……... ☐

Referrals for Pre-school age children starting school in September need to be received by 31st March of that year

Does the person with Parental Responsibility give permission for:

- **The child to be referred to Warwickshire SEND 0-5**
- **Information to be shared as necessary between Warwickshire County Council (WCC), South Warwickshire Foundation Trust (SWFT) and, if referring for an Autism Assessment, also Coventry and Warwickshire Partnership Trust (CWPT)**

Signature of person with Parental Responsibility ……..Date ……

Signature of Referrer…… ……...Date……..

Privacy Statement

Warwickshire's lawful basis for processing personal data is legal obligation. To see how we use your personal data and what your information rights are, please read our privacy notice available via the following web address: www.warwickshire.gov.uk/privacyids. It should be read in addition to the council's overall customer privacy notice at www.warwickshire.gov.uk/privacy, which includes the contact details if you have a complaint about your information rights. For general enquiries, please contact Warwickshire County Council 's Customer Service Centre on 01926 410410. For children accessing Warwickshire Preschool Autism Service please refer to: www.covwarkpt.nhs.uk/privacy

<table>
<tr><th colspan="4">Child and Family Information</th></tr>
<tr><td>First Name</td><td>Surname</td><td>D.o.B.</td><td>Gender
M/ F</td></tr>
<tr><td>Person/s with Parental Responsibility
Please include all those with PR</td><td>Relationship to child</td><td>Child Protection Registered
Y/ N</td><td>Child Looked After
Y/ N</td></tr>
<tr><td colspan="2">Child's Home Address

Tel:</td><td colspan="2">Address for Correspondence

Tel:</td></tr>
<tr><td colspan="2">Ethnic Origin</td><td>First Language</td><td>Siblings</td></tr>
<tr><td colspan="2">Born at Weeks</td><td></td><td></td></tr>
<tr><td colspan="2">Pre-school</td><td>Address</td><td>Contact Name and</td></tr>
<tr><td colspan="2">Times attending (days and hours) -</td><td></td><td></td></tr>
<tr><td colspan="2">In receipt of two year funding Y/N</td><td></td><td>Number</td></tr>
</table>

G.P.	Tel:
Address	

Professionals involved and contact number	
H.V.	Teaching and Learning
SaLT	O.T
Consultant	Social Worker
Physio	Other *(please specify)*

Referred by: Role Tel:	e-mail: address:

Child's information
Child's strengths:
Reason for referral
Child's physical skills:
Child's communication skills
Child's social interaction skills and behaviour:
Child's play skills
Child's self help/ independence skills
Has the child attended a two year review? **Y/N**
Additional relevant information

Outcome of Referral

When this form has been completed please retain a copy and give a copy to the person with parental responsibility. Please include copies of any additional relevant information, such as observations, reports or assessments. It is the responsibility of the person referring to keep the person with parental responsibility fully informed and to feed back the outcome of the referral. If referring for an Autism Assessment please complete the attached “Signs and symptoms form”