****

**Inclusion Service**

**Barnsley Portage Service**

**PO Box 634 Barnsley S70 9GG**

**Tel no: 01226 773577 Fax no: 01226 773599**

**adminintegratedinclusionservices@barnsley.gov.uk**

**Request for Involvement**

**When considering portage involvement the following criteria should be met:**

* The child is aged 0-4years and is not accessing a funded place in a setting for 15 hours or more.
* The child’s development is delayed in two different areas, cognition and learning, communication and interaction, physical development, sensory development and/or social and emotional development.
* The child’s parent/primary carer will be available to meet with the portage worker on a regular basis.

***Please complete this form fully and return to the above address or email***

**Requester’s Details**

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| --- |
| **Name: Address:****Role:*****I confirm that this referral has been fully discussed with parents/carers regarding the child detailed below and that they are in agreement with this request for portage service involvement*****Signature: Date:**  |
| **Requester’s email and telephone contact:** |

**Child’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** | **Forename** | **Date of Birth** | **Gender** |
| **Address** | **Parent(s)/Carer(s) Name(s)****Contact number(s)** |

**Please circle as appropriate**

|  |  |  |  |
| --- | --- | --- | --- |
| **Early Help Assessment (EHA)** | **Education Health and Care Plan (EHCP)** | **Looked after child (LAC)** | **Safeguarding concerns? Child In Need (CIN) or Child Protection (CP)** |
| **Y/N** | **Y/N** | **Y/N** | **Y/N CIN/CP** |

**Summary of reasons for requesting Portage Service Involvement**

**Indicate area(s) of need**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Communication and interaction** |  | **Cognition and Learning** |  | **Social, emotional and mental health difficulties** |  | **Sensory and/or physical needs** |  |

|  |
| --- |
| **Outline of child’s strengths and difficulties and reason for request for service involvement.** **Please attach any relevant reports.** |

**Please indicate agencies involved with the family and attach any relevant reports to this request**

|  |  |
| --- | --- |
| **Service/Practitioner** | **Name and Contact** |
| Health Visitor |  |
| Speech and Language Therapy Service |  |
| Paediatrician |  |
| Consultant |  |
| Physiotherapist |  |
| Occupational Therapist |  |
| Social Care |  |
| Hearing Support  |  |
| Vision support |  |
|  |  |
|  |  |
|  |  |