#### CONFIDENTIAL

# **BURY CHILDREN’S SERVICES**

# REQUEST FOR SERVICE INVOLVEMENT

# Sensory Needs Team (Vision)

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|  |
| Name of referrer:  |  |  |
|  |

## **Details of Child**

Surname ……………………………………………………………… First name(s) ………………………………………………………..

Date of birth ……../……../…….. Male Female Year group …….... Ethnicity ………………………………...

Home language ……………………………………………………… Is an interpreter needed? Yes No

Code of Practice: ....................................... Statement/EHC

Parent/carer name(s) and address …………………………………………………………………………….………………………………………

…………………………………………………………………………………………………….. Postcode: …………………………………….

Telephone number(s): Home …………………………….……. … Mobile……………………………………………………………

**School/Establishment:** ………………………………………………………………………………………………………….............................

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**EYE CONDITION:**

**Reasons for Request for Involvement:**

**Professional Involvement** (*Please check your files and record any known involvement of these agencies with names)*

□ Curriculum Language Access Service ……………………………………………………………...

□ Educational Psychologist …………………………………….………………………..

□ Social Inclusion Service (*Education Welfare/ Looked After Children/ Traveller Education) …………………………………………………..*

□ Additional Needs Team *-Communication & ASD/Medical Conditions & Physical Difficulties/ Speech & Language/ Portage/ Impaired/ Children’s Disability),* **please specify** ……………………………………………………………………………………………………………………………………………………………...

□ Medical Services *(including Occupational Therapy/Orthoptist/Physiotherapy/Speech & Language Therapy/Child & Family/Child Development Centre/Consultant Paediatrician/Child & Adolescent Mental Health Serv*ice), **please specify** ……………………………………………………………………………………………………………………………………………………………...

□ Education Otherwise Service (Pupil Learning Centre) – *Outreach Service/Ark*, **please specify** ……………………………......................

□ Other *(for example, voluntary organisations)* **please specify**  *..................................................................................................................*

**I have gained parental/carer consent for this referral** (*please tick appropriate box/boxes)***:**

* for the involvement of the Sensory Needs Team (Vision)
* for this Service to access any other documentation held by other professionals on my child.

Signed…………………………………………………….. Date ..…………………………………………………

Please retain a copy of this request in school

For involvement, please send a copy to Sensory Needs Team-Vision, 3 Knowsley Place, Duke Street, Bury,

 BL9 0EJ

**VITeam@bury.gov.uk**