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| **Form PCI 1S**  **Request for Professional Consultation and/or Intervention for Sensory Impairment** | Kent County Council Logo |

All requests for intervention for sensory impairment must include up-to-date clinical information of the child or young person’s hearing and/or vision.

This request must include the completed parental agreement to engage section (pages 3 and 4). indicated by **a written signature rather than an electronic or typed signature.**

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| For all referrals, please ensure you have a written signature and please email to  **hivimsi@kent.gov.uk** | | |
| If you need to send referrals via the post please send with a **written signature** to the following | | |
| **For Hearing Impairment please send to:**  Dan Coughlan  STLS Sensory Business Support,  Brook House,  Reeves Way,  Whitstable, Kent, CT5 3SS | **For Vision Impairment please send to:**  **Carolyn Lewis**  STLS Sensory Business Support,  **Cheriton House,**  **Folkestone,**  **Kent CT19 4QJ** | **For MSI/Deafblind please send to:**  **Carolyn Lewis**  STLS Sensory Business Support,  **Cheriton House,**  **Folkestone,**  **Kent CT19 4QJ** |

1. **Please tell us about the child or young person:**

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| **Forename** | **Surname** | **Sex** | **Gender Identity** | **Date of Birth** |
| Address  Postcode | | Ethnicity | | Language |
| Correspondence Address if different  Postcode | | Child in Care?  **Yes / No** | | Child in Care - Local Authority |

1. **Please provide contact details of the parent/carer:**

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| Full Name | Address  Postcode:  Telephone:  Email: | Relationship to Child/Young person |
| Full Name | Address  Postcode:  Telephone:  Email: | Relationship to Child/Young person |

**3. Please provide contact details of the Pre-School or School the child or young person attends:**

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| --- | --- | --- |
| Pre-School/School name | Address:  Postcode:  Telephone:  Email: | National Curriculum Year (if applicable) |

**4. What are the main concerns?**

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**5. What is the child or young person’s sensory need?**

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| **Type of Sensory Impairment:** | **Hearing Impairment**  **Yes/No** | | **Vision Impairment**  **Yes/No** | | **MSI/Deafblind**  **Yes/No** | |
| **Clinical Information provided**  (eg HI - audiogram or  VI - visual acuity information)  **Yes/No** | | | Specialist interventions are provided for children and young people with moderate, severe or profound sensory impairment.  Consultation and advice is provided for children and young people with mild or unilateral sensory impairment. | | | |
| **Is there any additional information you would like to tell us about the child or young person’s Special Educational Needs or Disability:** | | | | | | |
| **At Pre-School or School -the identified Level of SEN Need or SEN funding:** | | **SEN Support**  **Yes/No** | **EHCP**  **Yes/No** | **SENIF**  **Yes/No** | | **HNF**  **Yes/No** |

**6. Are any other professionals working directly with this child?** eg Social Care, Portage, Therapy Services, Specialists

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| **Other Agencies' Involvement** | **Key Name** | **Role** | **Contact Details** |
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**7. Other Information:**

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| Are there any issues regarding worker safety that should be taken into account in planning a response? | | |
| What are your expectations regarding this request? | | |
| Name of Referrer (Please print clearly) | Role | Date |
| Contact details of Referrer (address, telephone number, email address) | | |

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| **Form PCI 2S**  **Parents/Carers and Child/Young Person Views and Agreement to Engage** | Kent County Council Red and white Logo |

This form is for use when requesting advice and/or intervention to support meeting the needs of a child or young person with a sensory impairment. When completed it should accompany the form PCI 1S, both of which should be sent to the Coordinator for Hearing Impairment, Coordinator for Vision Impairment or Coordinator for Multi Sensory Impairment.

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| **Child/Young Person’s full name:** |  |
| **Date of Birth:** |  |
| **Parent/Carer - Full Name:** |  |

**Parent/Carer Views:**

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| **What would you like the outcome to be for your child?** |

**Child or Young Person’s Views:**

*Where it is appropriate to secure the views of the child or young person, these should be recorded here. It may be appropriate for the referrer or other professional to scribe for them.*

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| **What do you think might help you?** |

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| Where the referral is made for a very young child, or at the time of diagnosis, it may be considered inappropriate to seek child or parental views, and these will be recorded later by the initial key worker (eg Specialist Teacher, Early Years VI Play Specialist etc)  **If agreement to engage has not been sought, or if the parent/carer and/or child/young person has not given agreement, please say why.** |

**Parent/carer and child/young person agreement to engage**

*To ensure that the STLS Sensory Service can support you and your child, either at home or in a pre-school setting or school, we may need to speak with other professionals. These may include:*

*Teachers and School Professionals, Early Years Practitioners, Portage, Health Visitors, SEN Specialist Teachers, Educational Psychologists, Speech Therapists and Therapy Professionals, Audiologists, Audiovestibular and ENT Professionals, Optometrists, Orthoptists, Ophthalmologists, VI Clinic Liaison Professionals, Mobility Officers, Social Care and KCC SEN Officers.*

*These professionals work together to ensure the best possible Special Education Needs and/or Disability services and provision are in place for your child. You will be provided with copies of any reports or assessments written by professionals regarding your child.*

*Personal information will be used in line with data protection law as outlined in the SEND Privacy Notice. This can be found at:*

[*https://www.kent.gov.uk/about-the-council/contact-us/access-to-information/gdpr-privacy-notices/education/sen*](https://www.kent.gov.uk/about-the-council/contact-us/access-to-information/gdpr-privacy-notices/education/sen)

* **I agree to engagement from the STLS Sensory Service.**
* **I understand that information on my child’s special educational needs may be shared or discussed with other relevant professionals to help me/my child.**
* **I understand that I will be consulted regarding any future planning and actions.**
* **I understand that at any time I have the right to cease engagement by informing the STLS Sensory Service, although statutory services may continue to be provided.**

**Print name of parent/principal/main carer**:

Address

Phone number: Email:

**Written signature**: Date:

**Print name of child/young person:**

Signature of young person: Date:

(if appropriate)

**Referrer Details**

Print name: Role:

Service/Agency:

Signature: Date:

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