



RHONDDA CYNON TAF



MERTHYR TYDFIL  
County Borough Council  
Cyngor Bwrdeistref Sirol  
MERTHYR TYDFUL

## Educational Psychology Service Early Years Referral

This form outlines the reasons for requesting involvement from the Educational Psychology Service (EPS) and will be used to help determine the nature of any work undertaken by this service and to gain consent for any involvement with the child/young person named.

### How we use your personal information

In line with the Council's legal duty under Section 321 of the Education Act 1996, the information on this form, any additional information attached and any data produced as a result of this involvement (e.g. a report) will be used by the EPS to determine the nature of any work undertaken by this service. If appropriate, this process may involve sharing sensitive information about your child with external specialists e.g. health professionals.

To learn about how your privacy is protected and how and why we use your personal information to provide you with services, please visit our service privacy notice here [www.rctcbc.gov.uk/serviceprivacynotice](http://www.rctcbc.gov.uk/serviceprivacynotice) and the Councils data protection pages here [www.rctcbc.gov.uk/dataprotection](http://www.rctcbc.gov.uk/dataprotection).

Please tick area: Rhondda  Cynon  Taff Ely  Merthyr

Name of Child: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Home Telephone No: \_\_\_\_\_ Mobile No. \_\_\_\_\_

Which school do you anticipate the child will attend: \_\_\_\_\_

Early Years Setting/Playgroup (if applicable): \_\_\_\_\_ Contact No: \_\_\_\_\_

Is the child receiving Flying Start: Yes  No

Is the child receiving Portage: Yes  No

Parent(s)/ Carers Names: \_\_\_\_\_

Health Visitor/ Doctor's Name: \_\_\_\_\_ Contact No: \_\_\_\_\_

Child's strengths :

**Child's difficulties:**

**Please outline your concerns regarding child's development**

**Please tick if the child has any of the following difficulties:**

Medical Needs       Physical       Hearing/Visual Impairment

Behaviour / Wellbeing       Speech and Language       Social - Communication

**Please give details:**

**Is child known by, or has been referred to, any of the following? :**

Service	Please tick ✓	Contact name and number
Paediatrician		
Portage Service		
Speech & Language Therapy Service		
Physiotherapist		
Occupational Therapist		
Social Services		
Health Visitor		
Audiology / Ophthalmology		
Other (please state)		

Relevant information about family background.

Please tell us about the work that has already been done and in particular any specific strategies and interventions.

What was the frequency and duration of the support/strategies/interventions?

Please describe the outcome of your evaluation of the support/ strategies/interventions given so far and (if applicable), the progress made by the child including approximate development levels where appropriate (i.e. S.O.G.S, Portage checklist/Ruth Griffiths, Wellcomm etc). Evidence of a graduated response **must** be provided (see below). If unsure please ring and discuss.

**Please ensure all supporting evidence is attached and forwarded to the address below (please tick evidence of graduated response included).**

Medical report		Speech and Language report	
Ruth Griffiths Development Scales		Health Care plans	
Schedule of Growing Skills		Portage report	
Physiotherapy report /programme		Individual play plan	
Occupational Therapy report /programme		Wellcomm	
Community Nursery Nurse involvement		Other	

## Parent/guardian

**I consent to my child receiving involvement from the Educational Psychology Service and confirm that all personal details completed on this form, including address and date of birth, are correct. I will inform the Educational Psychology Service immediately if there are any changes to my address or contact details.**

Parent / guardian name:

Parent / guardian signature:

Date:

Additional notes:

Please indicate if you would like reports written by the EPS to be in Welsh  or English   
(A Welsh version of the report will be sent to school if requested by parent / guardian)

## Declarations

### Referrer

- I confirm that the information contained in this form (and any additional information attached) is accurate.
- I have made the parent/guardian aware of:
  - how the personal data will be used to identify additional support if appropriate.
  - how they can access their information rights and further information via the Data Protection pages of the Council's website.

Referrer's name:

Referrer's signature:

Referrer's designation

Date:

Referrer's address

Additional notes:

## Please return completed referral to:

FAO – Pink Box  
Educational Psychology Service (Early Years)  
Ty Trevithick  
Abercynon  
Mountain Ash  
CF45 4UQ  
Tel. No. 01443 744325/6/7/8  
Fax No. 01443 744125  
Email [A&IService@rctcbc.gov.uk](mailto:A&IService@rctcbc.gov.uk)