SWAP (Speak With A Picture)
Referral Form

(only referrals for preschool children aged 2-4 are eligible)

Section 1	**Person Making Referral:** **Professional** ☐ **Parent/Carer** ☐ Please tick appropriate box		
Name:		Address:	
Job Title:			
Telephone:			
		Email:	
Borough	Barking & Dagenham ☐	Havering ☐	Redbridge ☐

Section 2	**Child / Young Person's Details**		
Child's First Name: Child's Surname:		M ☐ F ☐	Date of Birth: Age in years and months:
Address:			Nursery / Preschool Name:
Postcode:			Nursery Tel No: Nursery Email:
Language:	Religion		Ethnicity:
Subject to Child Protection Plan / Child In Need: Y ☐ N ☐			Nationality
LAC Status:			

Section 3	**Parent or Carer's Details**
Who has parental responsibility?	Occupation:
Parent / Carer's Name:	Relationship:
Address: Postcode:	Home Telephone: Parent Mobile:
Parent email address: **(Please note all correspondence will be done via email)**	
Emergency Contact Name: Emergency Contact Telephone Number: Relationship to child:	

Section 4	**Please tick the boxes below to indicate other Professionals / Agencies involved, if known:**	
☐ Social Worker	☐ Nursery/Preschool	☐ Other (specify)
☐ Educational Psychologist	☐ GP	
☐ Health Visitor	☐ SENDCo	
☐ Child Development Team	☐ Children with Disabilities Team	
☐ Early Help	☐	

Section 5	Reason for referral: please indicate if your child is verbal/non-verbal and how do they currently communicate (pointing, how many words that they can say, leading by the hand etc.)

Section 6	Please tick the boxes below to indicate the services you have already been referred to:	
☐ Audiology	☐ Speech & Language Therapy	☐ First Step Opportunity Group
☐ Child Development Team	☐ Health Visitor	☐ Home Start
☐ SEND Early Years	☐ Children's Centre	☐ Other (please specify)
☐ Community Paediatrician	☐ Portage	
☐ Social & Communication Clinic	☐ Good Beginnings	

Section 7	Medical Information (does your child have any known medical conditions/diagnosis/allergies:

Section 8	Parent's/Carer's concerns / History of child's difficulties (what age difficulties first become apparent, have the difficulties stayed the same or worsened, what have you already tried to do to support your child with these difficulties and what has/has not worked) Impact of the difficulties on the child and immediate family:

Section 9	Family History including who lives in the family home, others with any illness or disability (e.g. Social Communication Disorder/Autism) in the family and if other siblings are known to child health services:

Section 10	Other relevant information including where you heard about the SWAP programme:

Section 11	Information Sharing And Consent:

Information about your child may be shared with other teams and agencies (eg services within the Sycamore Trust)

Has the referral been discussed with the parent or carer? ☐ **Yes** ☐ **No**

Is there parental consent for enquiry/onward referral to other services? ☐ **Yes** ☐ **No**

Comments (if any):

Signed (Parent/Carer) **Name:**

Signed (referrer): **Name:**

Relationship: **Date:**

How did you hear about SWAP: _____

Office Use Only

Name and designation of receiver:	Date:

Date placed on waiting list: _____

Date acknowledgement sent to parent: _____ Professional: _____

Place allocated: ☐ **Yes** ☐ **No** SWAP Ref No. SW/_____/18

How we use your information:

Sycamore Trust UK will use the information that you have provided in this form and all subsequent forms in order to provide the service requested. Your data will not be shared with third parties without your permission and will be stored in line with our Data Protection policy. If you would like more information about how your data is used, please read our Privacy Policy. http://www.sycamoretrust.org.uk/cookies-and-privacy-policy

I have read and understood the above on how my data will be used for this service.
I agree for Sycamore Trust UK to hold the data I have provided ☐ (please tick to show agreement)

To make a referral send this form to:
SWAP
Sycamore Trust UK
27/29 Woodward Road
Dagenham
Essex RM9 4SJ
E:mail SWAP@sycamoretrust.org.uk