 LINCOLNSHIRE COUNTY PORTAGE SERVICE

Lincoln and District Portage Service Referral Form

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| Child’s Name: DOB:  Address:  Tel No: | Name of Parent / Carer:  Next of Kin (if different from above):  Address:  Email Address:  Landline Tel No:  Mobile No: |

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| GP  Tel No: | Health Visitor  Tel No: | Home Language: |
| **Names of other professionals involved:**  Speech and Language Therapist (SALT)  Physiotherapist  Occupational Therapist  Educational Psychologist  Community Paediatrician  Consultant  Other | | |
| **Brief Description of Difficulties:** (To be eligible for Portage a child normally has delay in two or more areas of the Portage checklist) | | |

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| **Name of setting/group child attends and for how many hours.**  **Please note:** A child attending a setting for 5 or more sessions (15 hours) per week **may** not be eligible for Portage Home Visiting |

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| Referred by:  Address:  Tel no:  Signature: Date: | Please return this form, with parental permission, to:  Sue Shorthouse  Lincoln St Christophers School  Hykeham Rd  Lincoln  LN6 8AR  suzanneshorthouse@lincolnstchristophers.com  Tel no: 07789 075631 |