 LINCOLNSHIRE COUNTY PORTAGE SERVICE

Lincoln and District Portage Service Referral Form

|  |  |
| --- | --- |
| 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: |

|  |  |  |
| --- | --- | --- |
| GPTel No: | Health VisitorTel No: | Home Language:  |
| **Names of other professionals involved:**Speech and Language Therapist (SALT)PhysiotherapistOccupational TherapistEducational PsychologistCommunity PaediatricianConsultant Other  |
| **Brief Description of Difficulties:** (To be eligible for Portage a child normally has delay in two or more areas of the Portage checklist)  |

|  |
| --- |
| **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  |

|  |  |
| --- | --- |
| Referred by:Address:Tel no:Signature: Date: | Please return this form, with parental permission, to:Sue ShorthouseLincoln St Christophers SchoolHykeham RdLincoln LN6 8ARsuzanneshorthouse@lincolnstchristophers.comTel no: 07789 075631  |