

Low Incidence Needs Team (LINT) Referral Form

Pupil Name: Date of Birth: M F

School/Setting: Unique Pupil number:

NC Year Group:

Has a CAF been completed (if yes please attach): Yes No

Children Act (1989) status (if applicable):

Does the child have a Single Plan (EHCP)? Yes No

Is your referral for a Hearing or Visual impairment? (Or both?): HI VI Both

Does the child have any formal diagnosis? Yes No Unknown

If yes, please specify (include details of name of Hospital and Consultant):

Please give a brief description of the impact of these hearing/visual needs (ie reasons for referral):

Referrer details

Referrer's name:

Setting:

Position (SENCo, class teacher etc):

Contact number:

Email address:

Please return this form including completed Parental Consent Form overleaf to:

SENIT Business Support Team, Gateshead Council, Dryden Centre, Evistones Road, Gateshead NE9 5UR

Or by email to: callumsammons@gateshead.gov.uk

If you have any queries, contact the team of 0191 433 8763.