

**Audit of Special Educational Needs and/or Disabilities (SEND) -**

**Early Years Provision**

This is an audit to identify the children at your setting who require additional support for SEND. When completed, you should return it to eyinclusion@portsmouthcc.gov.uk

This will enable the early years inclusion team to prioritise and allocate appropriate support and guidance.

Please complete for all children identified with SEND. Please write 'NIL' across the audit if there are none and submit.

**The submission of this form assumes that parental consent has been sought and recorded to share this information.**

**Please make sure that your parents are informed and aware that this information is being shared with and held by the early years team.**

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| Please return by**Monday 9 October 2023**The submission of this form must be via the secure email link eyinclusion@portsmouthcc.gov.uk | **Name of early years provider:** **Name and role of person completing this audit:**  **Contact number: Date completed:** **Name of manager: Name of SENCo:**  |
| **Definition of terms:**

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| --- | --- | --- |
| \*SLCN = speech, language, or communication needsSEMH = social, emotional, and mental healthPMED = physical and medical diffGDD = global developmental delayND = neurodiverseHI = hearing impairmentVI = visual impairmentPD = physical disabilityOTHD = other difficulty/disability | **\*\***EYP = Early Years PanelSLT = Speech and LanguageHV = Health VisitorP = PortageCCP = Consultant Community PaediatricianVHT = Vision and Hearing teamPT = PhysiotherapyOT = Occupational therapyOther | **\*\*\***2yr old = 2 year old fundingDAF = Disability Access FundDLA = Disability Living AllowanceEHCP = Education, Health and Care PlanEYPP = Early Years Pupil PremiumSENDIF = Special Educational Needs and Disabilities Inclusion Fund emergingSENDIF+ = Special Educational Needs and Disabilities Inclusion Fund +  |

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| **Child's name** | **Date of birth** | **Year of school entry** | **Area of need\****(Circle all**that apply)* | **Details of outside agencies\*\*** | **Funding\*\*\*** | **What have you already put in place?****(Please give details e.g., SEN plan in place)** | **Are you making an EHC assessment request?** | **Would you benefit from additional advice, guidance, or support from the EY inclusion team?** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | SLCNSEMHPMED GDD ND HIVI PD OTHD | EYPSLTHVPCCPVHTPTOTOther | 2yr oldDAFDLAEHCPEYPPSENDIFSENDIF+ |  | **Yes/No**Are parents in agreement with the request?Do you need support to complete the request? |  |
|  |  |  | SLCNSEMHPMED GDD ND HIVI PD OTHD | EYPSLTHVPCCPVHTPTOTOther | 2yr oldDAFDLAEHCPEYPPSENDIFSENDIF+ |  | **Yes/No**Are parents in agreement with the request?Do you need support to complete the request? |  |
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Please continue if needed…