**Request for Children and Families Support**

We appreciate that we request a wealth of information. If you could provide as much information as possible it will enable us to provide the right support to the family and will mean the family will not need to duplicate this information.

**Section 1 – Basic details**

|  |  |
| --- | --- |
| Request Date:  Date family joined you: | |
| Family Address:  Postcode: | |
| Contact telephone number: | Home number:  Mobile:  Email: |
| Family GP | GP Name: Contact no:  Address: |
| Health Visitor: | Name: Contact no:  Address: |

**Parent/ Carers**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name | Date of Birth | Relationship to child | Ethnicity |
|  |  |  |  |
|  |  |  |  |

**Children** (please include all children in household and details of any pregnancy)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name | D.O.B | Gender | Ethnicity | Nursery or School |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Other people living in the family home/ or significant others.**

|  |  |  |
| --- | --- | --- |
| Full name | Relationship to child | Address if different to above |
|  |  |  |
|  |  |  |
|  |  |  |

**Safety and agencies supporting family**

**Has there been any current/historic/potential domestic abuse identified?**

Yes No

Please state:

**Referrer details:**

|  |  |
| --- | --- |
| Name:  Role:  Organisation:  Email: | Address:  Postcode:  Tel. no: |

**Other agencies currently involved with family** (Please tick and add names and numbers of professionals)

|  |  |  |  |
| --- | --- | --- | --- |
| Family Doctor  Name:  Number: |  | Speech and Language Therapy  Name:  Number: |  |
| Health Visitor/Midwife/ School Nurse  Name:  Number: |  | Paediatrician  Name:  Number: |  |
| Children’s social care  Name:  Number: |  | Inclusion Support Services  Name:  Number: |  |
| Adult’s social Care  Name:  Number: |  | Nursery/School  Name:  Number: |  |
| COG/ Early Help  Name:  Number: |  | CAHMS  Name:  Number: |  |
| Adult mental health/ drug/ alcohol  Name:  Number: |  | Other  Name:  Number: |  |

**Signs of Safety**

|  |  |  |
| --- | --- | --- |
| What are you worried about? | What’s working well? | What needs to change? |
| Harm: | Existing strengths:  Existing safety: | Safety Goals:  What needs to happen next? |
| Danger Statement: |
| Complicating Factors: |

**Request for support**

**What are the current presenting issues and the support you are requesting for these issues?**

|  |  |
| --- | --- |
| Please tick to all that apply |  |
|  | Physical Health including nutrition – please provide details |
|  | Parental Well-being – please provide details |
|  | Meeting children’s Emotional Needs – please provide details |
|  | Child Safety – please provide details |
|  | Parent Social networks/ Child social networks including being digitally excluded |
|  | Childrens Education and Learning – please provide details |
|  | Boundaries and Behaviour – please provide details |
|  | Family Routine – please provide details |
|  | Home and Finances – please provide details |
|  | Progression to work – please provide details |

**Current or previous assessments and plans in place.**

Are the children subject to a plan? Yes No

|  |  |
| --- | --- |
| Early Help – TAF plan  Lead professional:  Date of next meeting:  Last minutes attached: Yes No | Child Protection Plan  Lead professional:  Date of next meeting:  Last minutes attached: Yes No |
| Child in need plan  Lead professional:  Date of next meeting:  Last minutes attached: Yes No | Looked after child  Lead professional:  Date of next meeting:  Last minutes attached: Yes No |
| Single assessment  Lead professional:  Date of next meeting:  Last minutes attached: Yes No | Other |

**Early help note:** Yes No Date completed:

(If child is not currently subject to a statutory plan – please attach completed note)

**Family Star Plus Outcome star:** Yes No Date completed:

(please attach a copy of completed star and action plan)

**Consent**

Parents/ carer has consented to referral: Yes No

If no, family support to make a phone call to parent and explain further about their services and the support they can offer.

Referrers Name:

Position:

Referrers Signature:

Date:

**For Family Worker Only:**

|  |  |
| --- | --- |
| **Date referral received:** |  |
| **Date of initial contact made:**  **Home visit booked:** |  |
| **Area of support:**  Highlight relevant areas | Behaviour and boundaries  Behaviour Management  Positive Interactions  Transitions  Bereavement  Safeguarding  Health and Wellbeing  Communication and Language  Stay and play sessions  Coffee mornings  Social, emotional and mental  Loneliness and isolation  Housing  Benefits and finances |
| **Signposting (Specify service)** | Referral to other agencies:  Advice and Advocacy  Community Offer  Early Help  Social Services  Inclusion Services  ESOL  Local Offer  Befriending  Digicomm |
| **No further action (Specify reason)** |  |