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| **Referral for Early Help**    **This referral form is for organisations to request additional early help for a family, because the needs of a child are beyond the level of support that can be provided by universal services. It must be used after you have already provided some early action to address difficulties.**  **The expectation is that parents/carers have consented to this request for additional help but please discuss with us if there are difficulties with engagement.**  **Send this request to** [**earlyhelp@southwark.gov.uk**](mailto:earlyhelp@southwark.gov.uk) **or phone 020 7525 2714 for a consultation**  **If there are child protection concerns please refer direct to MASH ring 020 7525 1921 or complete the MASH referral form and send to** [**mash@southwark.gov.uk**](mailto:mash@southwark.gov.uk) |

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| 1. **Child / young person details** *– please fill out as fully as possible but don’t worry if some specific details are not known* | | | | | | | |
| Full name of child: |  | | | | | | |
| Any alternative name: |  | | | | | | |
| DOB: | Age:       Tick if estimated: | | | | If unborn, estimated date of delivery? | | |
| Gender | Male  Female  Unknown | | | | | | |
| Ethnicity |  | | | | | | |
| First language: |  | | Will an interpreter be required?  Yes  No | | | | |
| Current Home address |  | | | | | Post code |  |
| Previous home address (if known) |  | | | | | | |
| Telephone / Mobile |  | | Email | |  | | |
| School / Pre-school |  | | | Address: | | | |
| Does the child have a disability? | | Yes  No | | | | | |
| If yes give details of the disability: | | | | | | | |
| Unique Pupil Number (UPN): | |  | | | | | |
| NHS Number: |  | | | | | | |

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| 1. **Additional information about the child or young person (including other siblings)** | | | | | | | | | |
| **Parent / carer, children and others living in the household** | | | | | | | | | |
| Last name | First name | | Relationship to child(ren) | DOB / EDD | Gender | Ethnicity | Focus of referral Yes/No | School / preschool | Does this person hold Parental responsibility? |
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| **Other significant adults** | | |  | |  |  | | |  |
| Last name | | First name | Relationship to child(ren) | DOB | Ethnicity | Address | | | Does this person hold PR |
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| **In order to consider what additional help is needed please answer the following:** | | |
| 1. **What help have you or others provided to address the child or family needs? And why?**   Please send us any assessments you have completed and any Team around the Child or Family meeting | | |
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| 1. **What are you still worried about?** Please indicate the individual needs of the child(ren) and what needs to change for the child(ren) and why? What has prompted this referral now? | | |
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| 1. **What information do you know about the parent/carer and the wider family support network?** *(include relationships, friendships, behaviour, support, stability, safety, language, mental health, substance misuse, domestic abuse etc)* **Are there any risk issues we need to be aware of?** | | |
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| 1. **Details of other agencies working with the family** | |
| **GP** | |
| **Name**  **Address**  **Telephone number** |  |
| **Health visitor / School nurse / Midwife** | |
| **Name**  **Address**  **Telephone number** |  |
| **Other professional / agency (include agency name here)** | |
| **Name**  **Address**  **Telephone** |  |
| **Other professional / agency (include agency name here)** | |
| **Name**  **Address**  **Telephone** |  |
| **Other professional / agency (include agency name here)** | |
| **Name**  **Address**  **Telephone** |  |

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| 1. **Have you made any referrals to other services? If so please list below so early help can be coordinated** |
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| 1. **CONSENT** | | |
| ***The expectation is that parents/carers have consented to this request for additional help but please discuss with us if there are difficulties with engagement*.** | | |
| **What is the view of the parent/carer about this referral and what help they need for their child(ren)?** | | |
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| **Has consent been given for this referral from the Parent / Carer: Yes       No**  **Written/Verbal (please choose)** | | **Has consent been given for this referral from the Child / young person: Yes       No**  **Written/Verbal (please choose)** |
| **Who gave consent?** |  | |

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| 1. **Details of Person making referral** | | | | |
| Name of referrer |  | Job Title |  | |
| Agency |  | Address |  | Post code: |
| Telephone number |  | Email |  | |
| **Date of referral** |  | Signature |  | |

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| **Any other comments or information that would help us respond to this referral?** |
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