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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** **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** |

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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**
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| ***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)?** |
|  |
| **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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