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| **Request for Support****Services For Families During Pregnancy and Early Years (0-5 years)** |

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| **The Agreement**I understand that receiving Early Help support is voluntary and the information I give on this form will be shared with Knowsley Council to identify what support may be needed and to help plan support for me and my family. This may involve the sharing of my information with one or more of the following professionals / agencies were considered necessary so that they can help to plan and provide support for me and my family: - |
| * Education Providers e.g., nurseries, childminders, schools
* Social Care services
* Health- GPs or Health Visitors
* Counselling Services
* Housing Providers
 | * Local Job Centres
* Financial Advisors
* Merseyside Police
* Safer Communities
* Youth Justice and Probation Services
* Voluntary and Community Sector Bodies.
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| I understand that my information will be stored safely as per the General Data Protection Regulation. If you would like more information about how your information is processed, please ask your Practitioner, or see our website at https://www.knowsley.gov.uk/residents/early-years-support/knowsley-early-years-serviceI understand my information will be used to evaluate how successful and effective early help is at both local and national level. (All names or personal identifying information will be removed). I understand that where there is an immediate risk of harm, the practitioner will follow the Knowsley Safeguarding Children’s Partnership reporting procedures. |

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| **Early Help Assessment & WellComm Screening**If you are the lead professional for the child or family an Early Help Assessment should be attached to this request for targeted support.Please attach the WellComm Screening. If the EHA has been completed within the last month, please only complete details of subject child and what needs to happen section. |

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| **Verbal Consent gained from Parent/Carer: Yes / No** |

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| **Signed:****(Parent/Carer)** |  | **Signed:****(Parent/Carer)** |  |
| Print Name: |  | Print Name: |  |
| Date: |  | Date: |  |
| **Signed:****(Referrer):** |  |  |  |
| Print Name: |  |  |  |
| Date: |  |  |  |



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| **Family Details** |
| **Parent / Carer 1:** |  | DOB: |  | Ethnicity: |  |
| Parental Responsibility: |  | Home Address & Postcode: |  | Contact No. |  |
| **Parent/Carer 2:** |  | DOB: |  | Ethnicity: |  |
| Parental Responsibility: |  | Home Address & Postcode: |  | Contact No. |  |
| **Child’s Name:** |  | DOB: |  | Gender: |  |
| Ethnicity: |  | Lives with parent 1 or 2: |  | Education Provider: |  |
| **Child’s Name:** |  | DOB: |  | Gender: |  |
| Ethnicity: |  | Lives with parent 1 or 2: |  | Education Provider: |  |

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| **Additional details (Mandatory):** please include any information that will enable agencies to work in a more productive manner with the family e.g., risks/hazards to conducting home visits, highlight any communication needs the family may have or identify if an interpreter is required (and what language), observations/assessments. |
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| **Details of other agencies/provision involved with the Family/Child(ren)** |
| **Agency** | **Name of Key Professionals** | **Telephone / Email / Address** | **Current Involvement** |
| GP |  |  |  |
| Dentist |  |  |  |
| Health Visitor |  |  |  |
| Nursery Setting |  |  |  |
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| **What is working well?** |
| What existing support is in place for this child and family? What was the outcome of the Early Help Assessment? Are there support networks (e.g., family/friends/community) being accessed or services that are being provided to address the concern? |
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| **What are you worried about?** |
| What are the future worries for the child(ren)/family should this concern not be addressed? What are the complicating factors that make the worries more difficult to deal with? |
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| **What needs to happen next?** |
| What changes do the family need to make? What do they think will help them? What do you think would help to decrease the concern and risk to the child and their family? What support would help the family to make the changes you have identified? |
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| **Voice of the child?** |
| What did the child say? What are your observations of the child? What is the child’s view on what needs to happen? |
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| **Early Years for Support and Intervention Request** |
| Date of Request |  |
| Name of Referrer |  |
| Job Title/Agency |  |
| Address |  |
| Mobile/Telephone Number |  |
| Email Address |  |

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| Please complete this form to make a referral for Early Years Support and email to: knowsleyearlyyearsreferrals@knowsley.gov.ukPLEASE NOTE: Ensure all boxes are completed or referral will be declined and returned. Referrals without a Wellcomm Screening for language interventions will not be accepted.  |