Please email this form to [barrowreferrals@family-action.org.uk](mailto:barrowreferrals@family-action.org.uk)If you are requesting a single agency service, complete Part A and B. If your request is part of a multiagency package, complete Parts A, B and C.

Tick to confirm that the parent/carer/ young person\* has been given a copy of the Council’s Privacy Notice to read to make them aware that information on this form will be kept on a secure County Council database and will be accessed by a number of authorised people providing the 0 – 19 Child Family Support Service on behalf of Westmorland and Furness Council.

**PART A -** Please list ALL FAMILY MEMBERS

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Forename/s** | **Surname** | **DoB** | **Address**  (Please indicate if this is the primary  address\*\* for the child/ young person) | **Requires**  **Support from this Referral (Y/N)** | **Ethnicity** | **Parental**  **Responsibility**  **(Y/N)** | **Spoken Language** | **Disability**  **(Y/N)** | **Consented to Referral from this Service**  **(Y/N)** | **Gender/Self**  **Identification** |
|  |  |  |  |  |  |  |  |  |  |  |
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*\*Consent as per Gillick Competency \*\*Primary address is where child resides*

**Contact details:**

|  |  |  |
| --- | --- | --- |
| Name | Phone &/or Email | Please confirm preferred contact method |
|  |  |  |
|  |  |  |

**PART B** - To be completed by the person making this request.

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name:** |  | **Date of request:** |  |
| **Organisation:** |  | **Position:** |  |
| **Address:** | | **Contact number:** |  |
| **Email:** |  |
| **Signature:** |  |

**Other relevant professionals: If applicable, please identify the lead co-ordinator for EHA/CP/CiN**

|  |  |  |  |
| --- | --- | --- | --- |
| Health Practitioner: |  | GP: |  |
| School/ Nursery: |  | | |
| Any other agencies involved: |  | | |

|  |  |  |
| --- | --- | --- |
| **Reason for request for service (to complete with family):** | | |
| What are you worried/concerned about? | What is working well? | What will wellbeing and success look like? (What outcomes do you want for the child or young person?) |

**PART C** - To be completed if this is a request for support as part of a multi-agency package.

**Briefly describe support provided to the family by other agencies:**

**Are any of the assessments below in place for the Child or Young Person?** If so, please indicate and send a copy with the referral.

Early Help Assessment  Education, Health and Care Plan

CIN  CP  CLA Other: …………………………………………………………………………………………………………………..

If any of the above are ticked, a copy should be included with this request for service if the parent/carer consents.

**Is this a request for a step down? Yes/No.** If Yes, CSCP step down procedure must be followed. [Early Help Step Down](https://www.cumbria.gov.uk/elibrary/Content/Internet/537/6683/6687/6698/418448360.pdf)

[Cumbria Threshold Guidance (May 2022)](https://www.cumbria.gov.uk/eLibrary/Content/Internet/537/6683/6687/6698/17145/42632155941.pdf)

|  |
| --- |
| **Please provide current information e.g. Early Help Assessment, Signs of Safety tools, risk assessment if possible:** |

Office Use Only:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Received by:** |  | **Date received:** |  | **Date actioned:** |  |