Southwark Council

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

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:			

2. 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?

Other significant adults

Last name	First name	Relationship to child(ren)	DOB	Ethnicity	Address	Does this person hold PR

In order to consider what additional help is needed please answer the following:

3. 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

4. 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?

5. 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?**

6. 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**	

7. Have you made any referrals to other services? If so please list below so early help can be coordinated

8. 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)?	
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?	

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

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