**Request for Consideration of an Early Help Assessment**

**GP, A&E** **and Adult Mental Health Services Practitioners**

**This form is to be used by GP, A&E and Adult Mental Health Services Practitioners only**.

Please contact the Early Help Telephone lines with any questions or queries:

* Cumberland Early Help Team dedicated consultation advice and guidance number **0300 303 3896**
* Westmorland and Furness Early Help Team dedicated consultation advice and guidance number **0300 373 2723**

This form is to request Early Help Support for child(ren/young person(s)/family.

* It will be assessed by an Early Help Officer and the information will be shared accordingly with Early Help Support Services.
* On completion the Early Help Officer will confirm the outcome of the request by returning a Response to Request for Consideration of an Early Help Assessment form to the GP/A&E/Adult Mental Health Services Practitioner.

Please note: This form will be returned to the referrer if not completed in full. (All text boxes are expandable)

**Are the unborn baby, infant(s), child(ren) or young person(s), safe from harm?** Yes [ ]  No [ ]

**If you answered No, and you feel that there is a risk of significant harm, please follow the CSCP procedure for referral to the Cumbria Safeguarding Hub and do NOT complete this form.**

**Details of Child/ren/Family**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full name** (Enter all children/young people first) | **DOB** | **Gender** | **Ethnic Origin** | **Parental Responsibility** | **Address and contact****Telephone Number** |
|  |  |  |  |  |  |

**Reason for Request for Consideration of an Early Help Assessment**

Summary of what is working well and what you are worried about, including identified unmet needs for this unborn baby, or infant(s), child(ren) or young person(s)? Record evidence and comments in the boxes below: – start from the centre column to reinforce the positives

|  |  |  |
| --- | --- | --- |
| **What are the worries****(Including views of child/young persons and parents/carers).** | **What is working well****(Including views of child/young persons and parents/carers).** | **What will well-being and success look like? (Including views of child/young persons and parents/carers).** |
|  |  |  |

**Agencies supporting the family**

|  |
| --- |
| List all agencies (and contact details where known) and other support services who are currently involved with this unborn baby, infant(s), child(ren) or young person(s), or their family: |
|  |

**Additional Support Services**

|  |
| --- |
| What additional services are needed for the unborn baby, infant(s), child(ren) or young person(s), or their parent(s), carer(s) or family? |
|  |

**Additional Information**

|  |
| --- |
| Do you have any other information that you feel needs to be shared? |
|  |

**Have Parents/Carers given consent for an Early Help Officer to get in touch?**  Yes [ ]  No [ ]

**Do Parents/Carers give consent to the sharing of information with other professionals who may be able to support this Early Help Assessment?**  Yes [ ]  No [ ]

**GP/A&E Practitioner details**: (Full contact details of person Requesting Early Help Support).

|  |  |
| --- | --- |
| GP, A&E or Adult Mental Health Services Practitioner name |  |
| Agency |  |
| Address |  |
| Telephone Number:  |  |
| Email: |  |
| Date completed: |  |

Please note that this is not a referral for service and should not be used in place of an Early Help Assessment.

Please email the completed form to the relevant mailbox in the area the child resides:

**early.help@cumberland.gov.uk**

**early.help@westmorlandandfurness.gov.uk**