Multi-agency request for help

Agency / Service requesting help:		Agency/service help is required from:	
Name of Child / Children/Young Person:		Date of Birth:	
Address including Postcode:		CHI:	
School / Nursery / Day Centre attended:			
Class:			
First Language:			
GP Practice:			
Reason help is being requested / What do you need help with?			
Parent / Carers' understanding of the reason help is required:			
Childs understanding of reason why help is required [if possible]:			

Family Composition

Name	Date of Birth	Telephone Numbers	Relationship to Child / Children

Lead Professional / Named Person

Name of Named Person:	
Address:	
Telephone Number:	
Email Address:	

Name of Lead Professional:	
Address:	
Telephone Number:	
Email Address:	

Please list details of Team Around the Child (TATC) / other agencies currently involved:

Contact Name	Agency	Email address (if known)

Summary of Concerns leading to request and Desired Outcomes (only complete relevant sections):

Issue of Concern: If you have any supporting evidence, please include with the completed Request for Help form. NB: If the child or young person is on any prescribed medication it must be noted under the 'Healthy' indicator.

SAFE:
HEALTHY:
ACHIEVING:
NURTURED:
ACTIVE:
RESPECTED:
RESPONSIBLE:
INCLUDED:

Beyond Parental Control	
Bullying	
Child Alcohol / Substance Misuse	
Children Placing Themselves At Risk	
Child Exploitation (incl Sexual Exploitation)	
Child with Additional Support Needs	
Child with Mental Health Difficulties	
Child Trafficking	
Development Issues	
Domestic Abuse	
Emotional Harm / Abuse	

Neglect	
Non-engaging Family	
Parental Alcohol Misuse	
Parental Drug Misuse	
Parental Mental Health Problems	
Physical Abuse	
Sexual Abuse	
Young Carers	
Youth Offending	
Other Concerns – Details below	

Name of person requesting help:		Signature:	
Designation:		Agency / Service:	
Telephone Number:		Date help is requested:	
Contact Address of person making request:		Email Address of person making request:	

Consent Box

Please indicate whether you are in agreement with the information contained in this Multi Agency Request for Help Form being shared with other services (please tick). If agreement given verbally or otherwise, then please detail when and to whom.	None	Part	All
Please detail if this includes all services assessed as requiring input into your child's life or whether this is for certain services only, and if so which?			

Name		Signature	
Name		Signature	
Date			

- **Please send any completed forms for services through Education, Skills & Children's Services to: namedpersonleadprofessional@cne-siar.gov.uk**
- **If the service requested is a service delivered by Western Isles Health Board then the referral should be made directly to that service.**
- **For referrals to Third Sector services please send the referral directly to that service.**