Multi-agency request for help

Agency / Service requesting help		Agency/service help is required from	
Name of Child / Children/Young Person		D.O.B. CHI:	
Address		Postcode	
School / Nursery / Day Centre attended			
Class			
1st Language			
GP Practice			
Reason help is being requested / What does the child need help with?			
What interventions have been tried in the past or are currently underway?			
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

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

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

Emotional Harm / Abuse			

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			

- **Strictly for data analysis and strategic planning, please send any completed forms for services through Education & 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.**
- **The recipient of the referral must acknowledge receipt of the referral within 10 working days.**