**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) |
|  |  |  |
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**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 |  |  | Neglect |  |
| Bullying |  |  | Non-engaging Family |  |
| Child Alcohol / Substance Misuse |  |  | Parental Alcohol Misuse |  |
| Children Placing Themselves At Risk |  |  | Parental Drug Misuse |  |
| Child Sexual Exploitation |  |  | Parental Mental Health Problems |  |
| Child with Additional Support Needs |  |  | Physical Abuse |  |
| Child with Mental Health Difficulties |  |  | Sexual Abuse |  |
| Child Trafficking |  |  | Young Carers |  |
| Development Issues |  |  | Youth Offending |  |
| Domestic Abuse |  |  | 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](mailto: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.**