Please email this form to your local Family Hub:

South Lakes - [referralssouthlakesfamilyhub@westmorlandandfurness.gov.uk](mailto:referralssouthlakesfamilyhub@westmorlandandfurness.gov.uk)

Barrow – [ReferralsBarrowFamilyHub@westmorlandandfurness.gov.uk](mailto:ReferralsBarrowFamilyHub@westmorlandandfurness.gov.uk)

Eden - [ReferralsEdenFamilyHub@westmorlandandfurness.gov.uk](mailto:ReferralsEdenFamilyHub@westmorlandandfurness.gov.uk)

If you are requesting a single agency service, complete Part A and B.

If your request is part of a multiagency package, complete Parts A, B and C.

Tick to confirm that the parent/carer/ young person\* has been given a copy of the [Council’s Privacy Notice](https://www.westmorlandandfurness.gov.uk/your-council/data-protection-and-privacy/privacy-notice) to read to make them aware that information on this form will be kept on a secure Council database

**PART A -** Please list ALL FAMILY MEMBERS

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Forename/s** | **Surname** | **DoB** | **Address**  (Please indicate if this is the primary address\*\* for the child/ young person) | **Requires Support from this Referral (Y/N)** | **Ethnicity** | **Parental Responsibility**  **(Y/N)** | **Spoken Language** | **Disability**  **(Y/N)** | **Consented to Referral from this Service**  **(Y/N)** | **Gender/Self**  **Identification** |
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*\*Consent as per Gillick Competency \*\*Primary address is where child resides*

**Contact details**: *please complete contact details of the family member to contact*

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone &/or Email** | **Please confirm the preferred contact method** |
|  |  |  |
|  |  |  |

**PART B -** To be completed by the person making this request:

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name:** |  | **Date of request:** |  |
| **Organisation:** | | **Position:** |  |
| **Address:** | | **Contact number:** |  |
| **Email:** |  |
| **Signature:** |  |

**Other relevant professionals: If applicable, please identify the lead co-ordinator for EHA/CP/CiN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Practitioner:** |  | **GP:** |  |
| **School/ Nursery:** |  | | |
| **Any other agencies involved:** |  | | |

|  |  |  |
| --- | --- | --- |
| **Reason for request for service (Complete with family):** | | |
| **What are you worried/concerned about?** | **What is working well?** | **What will wellbeing and success look like? (What outcomes do you want for the child or young person?)** |

**PART C -** To be completed if this is a request for support as part of a multi-agency package.

**Briefly describe support provided to the family by other agencies:**

**Are any of the assessments below in place for the Child or Young Person?** If so, please indicate and send a copy with the referral.

Early Help Assessment  Education, Health and Care Plan

CIN  CP  CLA Other:

If any of the above are ticked, a copy should be included with this request for service if the parent/carer consents.

|  |
| --- |
| **Please provide information on any risks you are aware of (including in the home) and attach risk assessment if possible:** |

Office Use Only:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Received by:** |  | **Date received:** |  | **Date actioned:** |  |