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| **The Practitioner and Family have worked together and now feel that a Multi-Agency discussion via an Early Help Gateway Meeting will help to identify further specific support that can offered.** |
| **Information Sharing and Consent:**As the person helping you to complete this form has explained, we want to be able to provide services to you and your family. To do this efficiently, we will need to share some of the personal information you have supplied with services already working with you or that you may benefit from.  Please agree to this by signing below.  I agree to the sharing of information between the relevant agencies and all family members including young people as appropriate. I understand that the information gathered regarding my family is recorded and will be securely stored and used for the purpose of providing services to my family and may also be used for monitoring and auditing.Name Signature Date **Is there anyone you do NOT want us to share information with?**.............................................................. |

**Family Details**

 *(Please include all family member details and as much information as possible to enable quick access to support)*

**Is this a Self-Referral? Tick box to confirm** [ ]

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname, Forename/s** | **DoB** | **M/F** | **Relationship to Child 1** |
|  |  |  | **N/A Child 1** |
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**Address Details**

|  |  |
| --- | --- |
| **Address**  |  |
| **People with parental responsibility** |  |
| **Contact details** |  |
| **Significant others living or visiting the family home** |  |

**Details of Practitioner completing this form.**

|  |  |
| --- | --- |
| **Name and Role**  |  |
| **Organisation and address** |  |
| **Contact number/s** |  |
| **Email Address** |  |
| **Signature**  |  |

**Details of all known agencies/professional involved and any referrals made**

|  |  |  |  |
| --- | --- | --- | --- |
| **Organisation** | **Named Professional** | **Job Role** | **Contact Details** |
|  |  |  |  |
|  |  |  |  |

**Referral information**

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| --- |
| **Please tick primary area of concern/s or emerging needs** Accommodation[ ]  Family/Home[ ] Education/skills [ ] Financial/ Employment [ ]  Criminal/Anti- social [ ]  Health/Sleep [ ]  **Please give further details of concern/s or emerging needs:****What support has already happened and how did this go?** |

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| **Parents/Carer views on the current situation**How are things going? 1 2 3 4 5 **6 7** 8 9 10  ☹ ☹ ☹ 😐 😐 ☺ ☺ ☺ ☺ ☺**Comments (including child/young person’s view if available)** |

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| --- |
| **Key area of support requested** Support to learn [ ]  Health and Well-being [ ]  Parenting [ ]   Life Skills [ ]  Family and relationships [ ]  **Suggested support required or any additional comments:** |

|  |
| --- |
| **Provide details of any known risk factors or additional family needs (e.g. home, environment, people, pets, language)** |

Please send the completed form to your Area Multi Agency Support Team by secure email or fax