Please email this form to [BarrowReferrals@family-action.org.uk](mailto:BarrowReferrals@family-action.org.uk). If you are requesting a single agency service, complete Part A and C. If your request is part of a multi-agency package, complete Parts A, B and C.

**PART A**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child or Young Person Name(s)** | **Date of Birth** | **M/F** | **Disability**  **Yes/No** | **Ethnicity** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Visitor:** |  | **GP:** |  |
| **School:** |  | | |
| **Other agencies involved:** | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Parent/Carer(s) Name(s)** | | **Address and Post Code** | | | | **Disability**  **Yes/No** | **Ethnicity** | | **Parental Responsibility Yes/No** |
|  | |  | | | |  |  | |  |
| **Email:** |  | | **Tel:** |  | | **Mobile:** |  | | |
| **Preferred contact method:** | | |  | | **Spoken Language:** | | |  | |

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

Tick to confirm that the parent/carer understands that information on this form will be kept on a secure County Council database and will be accessed by a number of authorised people within the 0 – 19 CFSS service and People Directorate. Click here to view our [**Privacy notice**](https://www.cumbria.gov.uk/eLibrary/Content/Internet/536/17354/4324395910.pdf)

Tick to confirm that the parent/carer consents to us redirecting this referral to another service if we feel that this would be the most appropriate course of action

**PART B –** 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?**

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.

Is this a request for a step down? Yes/No. If Yes CSCP step down procedure must be followed

[Early Help Step Down](https://www.cumbria.gov.uk/elibrary/Content/Internet/537/6683/6687/6698/418448360.pdf)

|  |
| --- |
| **Please provide information on any risks that you are aware of (attach existing risk assessment):** |

**PART C –** To be completed by the person making this request

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

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