**Child and Family Details**

Child/ Young Person’s Surname:

Child/ Young Person’s First Name:

Date of Birth:

Gender:

Disability:

Religion:

Ethnicity:

First Language:

In Education/ Employment or Training: Yes No

Name of Nursery/School/College:

Current home address:

Postcode:

Siblings Names and Date of Birth…………………………………………………………………………………………………………

**Families’ areas of concern (tick box)**

Education

Early years development

Mental and physical health

Substance Use

Family relationship

Abuse and Exploitation

Involvement with Crime

Domestic Abuse

Secure housing

Financial stability

**What has led you to have this conversation with the family?** *(Open text)*

**What are the family seeking support with?** *(Open text)*

**What support do you, and the family, think will make a difference?** *(Open text)*

**Completed by:**

I consent to working with Early Help Services to help meet the needs of my family.

I consent to my information being shared with early help partners to develop a package of support for my family

If there are any partners, you would not like us to share your information with, please name them below:

Signed by parent/career………………………………………………………………………………………………………………………

Parent/career name and telephone number contact ………………………………………………………………………….

Please email this referral form for Early Help Support to helpandprotection@lambeth.gov.uk