

## St Helens Children and Young Peoples Service Request Form

This form should be used to make a referral to St Helens Children and Young People Services.

If you have any questions regarding completing the form or would like to discuss your concerns with a member of staff, please contact the **Contact Cares team on 01744 676600**. The Contact Carers Team is available between 9am and 4:30pm (Mon to Thurs) and 9am to 4pm (Fri). **If you send your service request form outside of these hours it may not be read/ actioned by a member of the team until the next working day.**

Out of normal hours (including evening, weekends and bank holidays), please contact the **Emergency Duty Team on 0345 050 0148**.

**Where you believe there is an immediate risk of significant harm, please contact the police on 999.**

**All sections of this service request form MUST be completed. If all sections are not completed the form will be returned to the referrer with the request for additional information to be provided. Note; the contact will not be generated until this information has been provided. If the form is not returned within 24 hours, the contact will be closed.**

**In relation to the St Helens Levels of Need Framework:**

**What is your concern/ reason for referral?**

- Early Help & Support (Level 2 of St Helens Continuum of Need Framework)  
 Statutory intervention (Level 3 of St Helens Levels of Need Framework)  
 Immediate Child Protection concerns (level 4 of St Helens Levels of Need Framework) **–must be rung through to the Contact Carers Team on 01744 676600 without delay and followed up in writing within 24 hours of making the call.**

If a disclosure is made, where possible details of the date, time, person involved are to be gained. Does the child/young person have a mark or bruise? Are they scared to go home?

**For all levels of need you must ensure parent/carers have been informed of the referral unless there is evidence that to inform them would put the child or other children at greater risk of harm.**

### CONSENT & CONFIDENTIALITY

If your referral relates to **Early Help & Support** (level 2) you **MUST** have the parent/carers **FULL CONSENT** and be able to answer YES to all of the below questions. If this is not the case then the referral will not be accepted.

If your referral relates to **Statutory intervention** (level 3) then you **MUST** have **INFORMED CONSENT** from the parent/carer for the child in order to make the referral. This means that the person giving consent should understand:

- Why the information needs to be shared
- What information is being shared
- What the information will be used for
- What the implications of sharing information are.

**If you have not discussed the details of the referral with the parent/carer, St Helens People services will be unable to progress your referral or make any contact with the family unless the concerns are of a child protection nature (level 4).**

Have you discussed your concerns with the parent/carer and subsequently advised them that you are making this referral?	YES	NO	(Delete as appropriate)
Has the parent/carer given consent to the referral been made?	YES	NO	(Delete as appropriate)
Has the parent/carer agreed that key agencies can be contacted by St Helens people services e.g. school, health and police? This may include school being asked to complete "my views" with the child/children?	YES	NO	(Delete as appropriate)

**Please provide an overview of the parents/carers views.**

### EARLY SUPPORT & EARLY HELP ASSESSMENT TOOL (EHAT)

**Any concerns which are not of an immediate Child Protection nature should be discussed or escalated within your own agency or setting before you consider a referral to children's services (e.g. discussion with the Designated Safeguarding Lead or your Line Manager).**

**It is essential that professionals work in partnership with families. For this reason if your referral is not in respect of immediate safeguarding concerns you should, prior to making this referral, consider initiating an EHAT plan or implementing Family Action Meetings with the family. This early help & multi agency support may assist the family in addressing issues as soon as they arise and ensure that support needs do not escalate to statutory level prematurely.**

**If you have not considered an EHAT it is likely your referral will not progress past the screening stage. It is also likely that the outcome of your referral will be for you to complete an EHAT.**

Has an EHAT plan been completed or considered prior to this referral being made?	YES	NO	(Delete as appropriate)
If yes, Name and role of lead professional			

If yes, address and contact details of lead professional		
If yes, have you discussed your concerns with the lead professional? <b>PLEASE DISCUSS YOUR CONCERNS WITH THE LEAD PROFESSIONAL BEFORE MAKING THIS REFERRAL UNLESS YOUR CONCERNS ARE LEVEL 4 ON THE CONTIUUM OF NEED</b>	YES	NO (Delete as appropriate)
If yes, please provide details of <u>dates</u> and <u>outcomes</u> of EHAT plans/ Family Action Meetings <i>Attach of copy of the last plan/assessment with this referral form</i>		
If no, why?		

REFERRER DETAILS (complete in full)			
Date of referral		Time of Referral	
Name of Referrer		Role/Profession	
Agency/ Organisation		Office phone number	
Office Address		Mobile phone number	
Email address- <b>this must be provided in order to receive a response in respect of the referral outcome</b>			

CHILD/ YOUNG PERSON DETAILS			
Family name		First name	
DOB/ Expected date of delivery (EDD) for unborn		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unborn
Address			
Current Address (if different to usual home address)			
	<b>Please ensure that you provide up to date contact numbers as this will ensure full screening can be completed.</b>		
Home telephone number			
Mobile phone number for parent			
Mobile phone number for young person			
Disabilities (Y/N) If Yes please state			
Is there an Education Health care Plan (EHC Plan) in Place?			

FAMILY DETAILS HOUSEHOLD MEMBERS						
Name <i>Start with primary care giver</i>	DOB/Age	Gender	Relationship to child/young person	School or Nursery	GP	Parental Responsibility (Y/N)

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**SIGNIFICANT OTHERS – NOT OF THE HOUSEHOLD** (for example parent or half sibling not living as part of the household)

Name <i>Start with parent if not living with child</i>	DOB/Age	Gender	Address	Relationship to child / young person	Does this person hold parental responsibility? Y/N	Is this person a known risk to children? Y/N

**REASON(S) FOR CONTACT OR REFERRAL**

What are you worried about?  
 What is the IMPACT (or potential impact) on the child/ren/young person(s)?  
 Is there any support EVIDENCE?  
 (Refer to the development of child/young person – health, behaviour, family relationships, signs of neglect)  
 If the child is less than 5 years old have you made a referral to the Children's Centre?

**What's working well? (Existing strengths and safety)**  
 Are parents engaging with professionals and what difference has this made?

**What needs to happen? (Future safety planning)**  
 What do you want Children and Young people Services to do with this information?

**The Child/ren / Young Person(s) Voice**  
 What did the child/young person say? What are your observations of the child/young person? What is the child's/young person's view on what needs to happen?  
 Attach my views document alongside this referral if completed

Outline your agency's role / service provided to the child and/ or family and your knowledge of the child/ young person's needs and parenting capacity to meet these.

What action have you / your agency taken to date to address the concerns?

Is there any additional support/signposting that you could offer which would reduce or manage the concerns?

Have you considered completing an Early Help Assessment Tool (EHAT) or convening a Family Action Meeting (FAM)?

(If you or your agency have already completed a EHAT please attach it with this referral form)

Could you initiate an EHAT plan to address the issues now?

**Agencies working with The Child/children/ Young Person(s)**

AGENCY	NAME	TEL:	AGENCY	NAME	TEL:
Education Welfare Officer (EWO)			Nursery		
School			Health Visitor (HV)		
School Nurse			Youth Justice Service		
Community and Adolescent Mental Health Service (CAMHS)			Community Paediatrician		
Police			Other		

**ETHNICITY**

The children's social care method of determining a child/young person's ethnicity involves first asking the child/young person about their ethnic identity. If they are not yet old enough to respond, ask their primary carer.

Ethnicity is now specified using the codes within the Common Basic Dataset (CBDS). The ethnicity of unborn children should be coded under "Information not yet obtained", even if it is thought to be known.

***This item should not be left blank.***

White British	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Any other Black background	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Traveller of Irish Heritage	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>	Any other Asian	<input type="checkbox"/>	Any other	<input type="checkbox"/>

				background		ethnic group	
Any other White background	<input type="checkbox"/>	Any other Mixed background	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	Refused	<input type="checkbox"/>
Gypsy/Roma	<input type="checkbox"/>	Indian	<input type="checkbox"/>	African	<input type="checkbox"/>	Information not yet obtained	<input type="checkbox"/>
<b>RELIGION</b>							
Christian	<input type="checkbox"/>	Jehovah Witness	<input type="checkbox"/>	Taoist	<input type="checkbox"/>		<input type="checkbox"/>
Atheist	<input type="checkbox"/>	Muslim	<input type="checkbox"/>	Not Known	<input type="checkbox"/>		<input type="checkbox"/>
Hindu	<input type="checkbox"/>	Sikh	<input type="checkbox"/>	Other Religion	<input type="checkbox"/>		<input type="checkbox"/>
Buddhist	<input type="checkbox"/>	Mormon	<input type="checkbox"/>	Refused to say	<input type="checkbox"/>		<input type="checkbox"/>
Jewish	<input type="checkbox"/>	Jainism	<input type="checkbox"/>	No Religion	<input type="checkbox"/>		<input type="checkbox"/>
If 'Other Religion' category chosen, please give details:							
<b>First Language</b> Child/ren				<b>Interpreter Required?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<b>First Language</b> Parent/Carer				<b>Interpreter Required?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	

Please email the completed Service Request form to the Contact Centre:

[adultandchildrenteam@sthelens.gov.uk](mailto:adultandchildrenteam@sthelens.gov.uk)