**Referral to an Early Help and Family Support Panel**

**Cumberland Council**

In order to be able to provide the panel with as much information as possible it is important that this form is populated with all relevant detail. It may delay discussion if there are gaps.

|  |  |
| --- | --- |
| **Name(s):** |  |
| **Address:** |  |
| **Date of Birth/EDD:** |  |

**Details of all family members listed on the Early Help Assessment:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Date of Birth** |
|  |  |  |

|  |  |
| --- | --- |
| **Name of family GP:** |  |

**Reason for referral to Panel**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Step Down:* | | |  | | | |
|  | | |  | | | |
| *Identification of Co-ordinator:* | | |  | | | |
|  | | | | |  | |
| *Progress to meet needs identified has slowed or stopped – the situation is ‘Stuck’:* | | | | |  | |
|  | | | | | | |
| **Date EH Initiated:** |  | | | | | |
|  | |  | |  | |  |
| **Date of last TAF review:** | |  | | **Number of TAF reviews held:** | |  |

**List the members of the TAF including all the family members:**

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**Record list of actions on the Early Help Plan indicating whether met or unmet with the name of the agency responsible for the action:**

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|  |

**What is working well?**

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**What are you worried about?**

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|  |

**What needs to happen?**

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**What are the views of the Parent/carer and/or Young Person on the referral and what do they hope to happen as a result**

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|  |

I, the referrer, confirm I have **CONSENT** from the **Parent/Carer or Young Person** for this to be referred to the Early Help and Family Support Panel and for information to be shared with panel members. Also that they have received the Information leaflet outlining details of the panel: **YES  NO**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer’s Name:** | |  | | | **Agency:** | | Choose an Agency | | | | |
|  |  | | | | | | | | | | |
| **E-mail:** |  | | | | | **Contact No:** | | |  | | |
|  | | |
| **Referrer’s Signature:** | | |  | | **Date Referral sent to Panel:** | | | | | |  |
|  | | | | | | | | | | | |
| **Parent/Carer or Young Person’s Signature giving consent:** | | | |  | | | | **Date:** | |  | |

**Please discuss this referral with your local Early Help Officer (contact details on the CSCP website) prior to sending the completed referral form to:** [earlyhelp.panels@cumberland.gov.uk](mailto:earlyhelp.panels@westmorlandandfurness.gov.uk)