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| **Early Help Hub Referral** |

**Important: you must gain consent for this referral (see overleaf)**

1. **Details of person making the Early Help Hub Referral**

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| --- | --- | --- | --- | --- | --- |
| Name |  | Role |  | Agency |  |
| Tel no |  | Email |  |
| Date of referral |  |

1. **Family Contact Details**

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| --- | --- |
| **Home Address** (including postcode) |  |
| **Telephone numbers**  |  |

1. **Family Member**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Live in household(Yes / No) | Nursery / School / College | Family member, eg mother, son | Date of birth | Gender |
| Adult 1 |  |  |  |  |  |  |
| Adult 2 |  |  |  |  |  |  |
| Adult 3 |  |  |  |  |  |  |
| Child 1 |  |  |  |  |  |  |
| Child 2 |  |  |  |  |  |  |
| Child 3 |  |  |  |  |  |  |

(Tab down to increase rows)

1. **Why are you making an Early Help Hub Referral for this child/young person/family?**

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|  What are the key difficulties for this child/young person/family? |

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| What additional help does this child/young person/family need? |

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| **Parent/carer comment** |  |
| **Child / young person comment** |  |

1. **Indicators of Risk**

Please tick where you know these to be factors. Leave blank if you are unsure.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Risk** | **Child 1** | **Child 2** | **Child 3** | **Child 4** | **Child 5** | **Child 6** | **Adult 1** | **Adult 2** | **Adult 3** |
| Carer |  |  |  |  |  |  |  |  |  |
| Crime / Anti-social behaviour |  |  |  |  |  |  |  |  |  |
| Domestic Violence (physical) |  |  |  |  |  |  |  |  |  |
| Domestic abuse (emotional) |  |  |  |  |  |  |  |  |  |
| Emotional wellbeing |  |  |  |  |  |  |  |  |  |
| Physical wellbeing |  |  |  |  |  |  |  |  |  |
| Homelessness |  |  |  |  |  |  |  |  |  |
| NEET |  |  |  |  |  |  |  |  |  |
| At risk of NEET |  |  |  |  |  |  |  |  |  |
| Poor school attendance  |  |  |  |  |  |  |  |  |  |
| School exclusions |  |  |  |  |  |  |  |  |  |
| Teenage pregnancy  |  |  |  |  |  |  |  |  |  |
| Relationship issues |  |  |  |  |  |  |  |  |  |
| Risk of sexual exploitation |  |  |  |  |  |  |  |  |  |
| Substance misuse  |  |  |  |  |  |  |  |  |  |
| Worklessness  |  |  |  |  |  |  |  |  |  |
| Special Educational Needs |  |  |  |  |  |  |  |  |  |

1. **Have you made any other referrals for this child/young person/family?**

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| --- | --- | --- |
| Family Member | Date | Agency - main reason  |
|  |  |  |
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1. **Are there any other professionals involved?**

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| --- | --- | --- |
| **Name** | **Role** | **Contact details** |
|  |  |  |
|  |  |  |

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1. **Any other assessments made for this child/young person/adult?**

Please ensure you attach with this referral any relevant assessment already made and supporting documents.

1. **Consent**

Ensure consent is obtained from the family for a referral and for sensitive information to be shared with professionals in the Early Help Hub. Please note anybody over 13 years, who is deemed competent, can give their own consent. This may be with or without parental consent.

I agree to this referral and to my information being shared with agencies who are part of the Early Help Hub response.

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| --- | --- | --- |
| **Signed young person, parent/carer signature** | **Name** | **Date** |
|  |  |  |
|  |  |  |

**Consent withheld**

Any individual or service the family would **not** wish information to be shared with

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| --- | --- | --- |
| **Name** | **Service / Relationship** | **Detail of information not to be shared** |
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**Detailing where consent not required**

Consent is not required in the following circumstances:

* Alleged or proven criminal activity
* Child protection or safeguarding of children and vulnerable adults, in which case this would become an immediate Multi-Agency Safeguarding Hub (MASH) referral

If you have not gained consent please detail below what of the two circumstances above applies to this referral and tell us why you have not made a referral to the MASH

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1. **Monitoring Information**

To be filled in by or with the child / young person / parent / carer

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Child 1** | **Child 2** | **Child 3** | **Child 4** | **Child 5** | **Child 6** | **Adult 1** | **Adult 2** | **Adult 3** |
| Ethnicity(please specify) |  |  |  |  |  |  |  |  |  |
| First language (please specify) |  |  |  |  |  |  |  |  |  |
| Religion or belief (if any)(pleasespecify) |  |  |  |  |  |  |  |  |  |
| Disability(pleasespecify) |  |  |  |  |  |  |  |  |  |
| Immigration Status(please specify) |  |  |  |  |  |  |  |  |  |
| Sexual orientation(please specify) |  |  |  |  |  |  |  |  |  |
| Gender identity(please specify) |  |  |  |  |  |  |  |  |  |
| Pregnancy / maternity(Yes/No) |  |  |  |  |  |  |  |  |  |
| Married / civil partnership(Yes/No) |  |  |  |  |  |  |  |  |  |
| Armed services(Yes/No) |  |  |  |  |  |  |  |  |  |

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| --- | --- |
| **For office use only:****Early Help Hub Referral ID number:**(allocated by the Early Help Hub) | **Date referral received:**  |

**What happens next?**

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| Send this referral with any additional supporting documents to the Early Help Support Team earlyhelp@brighton-hove.gcsx.gov.ukIf you need any help in completing this form please contact the Early Help Support Team**Telephone enquiries: 01273 292632 Monday to Friday 9am - 4.30pm.**  |

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| The Early Help Support Team receives your referral and logs it.**Please note – Referrals received up to 12pm on a Thursday will be discussed at the following Monday morning Weekly Allocations Meeting.**  |

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| The Early Help Hub will carry out **additional checks** against a range of databases to ensure we are as well informed as we can be about the referral. |

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| Your referral, together with the added information, will be discussed at the **Early Help Weekly Allocations Meeting**. This is a meeting of managers across Early Help who assess referrals to see what support could best be offered. Then either: |

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| You will be contacted after the Meeting and told what support we think could be offered, and the timescales for offering that support. The Early Help Hub is the direct route to accessing services such as the **Youth Service, the Integrated Team for Families, Youth Employability Service, and Youth Crime Prevention.** We may also agree that support will be offered by **School Nurses, Health Visitors or other services linked into Early Help.**  |  | The referral might be passed onto the **Mentoring team** to either:1. Look more closely into the case, because we feel we don’t know enough to make a decision.
2. Offer you support as a professional (similar to the CAF mentoring currently in place)
3. Support you in accessing services that sit outside the Early Help Hub but who we think can help.
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