Family Support Services & One Family Hub Request for Service Form

(Formally FaSST, Children’s Centres and IFSS)

## Request Details

|  |  |  |
| --- | --- | --- |
| **Date of Request:** | Click or tap to enter a date. | |
| **Time of Request:** |  | |
| **Is specific Out of Hours intervention required?** | Yes | No |
| **Is this request urgent?** | Yes | No |
| **If ‘Yes’, please outline reasons why** |  | |

## Referrer Details

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of referrer:** |  | | | | | | | | | | | | |
| **Agency:**  ***Please tick as appropriate*** | SPOC  IMAP  Social Work  CAMHS  Health Visitor |  | | GP  School Nurse  Midwife  Police | |  | Education  School  Nursery  College | |  | | Portage  Alternate Provision  One Family Hub  Self-Referral |  | |
| **Telephone No.:** |  | | | | | | | | | | | | |
| **E-mail address:** |  | | | | | | | | | | | | |
| **Referral Pathway:**  ***Please tick as appropriate*** | Outcome of SPOC  Outcome of Contact Referral  During completion of CSA  Completion of CSA  Outcome of 0-2 Pathway | |  | | Social Work Pod Discussion – Stepdown  Social Work Pod Discussion – Joint Work  PITSTOP Meeting  MAPLAC  Early Years Triage | | |  | | 2 Year Funding List Best Start Integrated Health Meeting  Self-presentation by Family  Direct E-mail Request | | |  |

## Family Composition

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name** | **Surname** | **Relationship** | **DOB** | **Care First Number** | **Address** | **Telephone** | **Email** | **Parental responsibility**  **Y/N** |
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## Significant others

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name** | **Surname** | **Relationship** | **DOB** | **Care First Number** | **Address** | **Telephone** | **Email** | **Parental responsibility**  **Y/N** |
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## Current Lead Worker

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Lead Worker Name** | **Service** | **Telephone no.** | **Email** | **Current Plan Type** |
|  |  |  |  | Choose an item. |
| **Date of Last Assessment or start date or Current Assessment:** | |  | | |

## Reason for Request

|  |
| --- |
| **Please summarise the presenting concern/risk/need (including reference to relevant SPOC, Contact Referral or CSA as appropriate)** |
|  |

|  |  |  |
| --- | --- | --- |
| **Are the family aware of this request to Family Support Services?** | Yes | No |

|  |  |  |  |
| --- | --- | --- | --- |
| **Has this request been discussed with The One Family Hub or**  **Family Support Services?** | Yes  No | **If yes, who?** | **Date** |
|  |  |

\*If this request requires immediate consideration, please complete this request AND hold a discussion with a Family Support Service Team Leader or The One Family Hub.

**Once completed, this form should be submitted via email to fasst.enquiries@northlincs.gov.uk;**