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  | [ ] [ ] [ ] [ ] [ ]  | GPSchool Nurse MidwifePolice  | [ ] [ ] [ ] [ ]  | Education School NurseryCollege | [ ] [ ] [ ] [ ]  | PortageAlternate ProvisionOne Family HubSelf-Referral | [ ] [ ] [ ] [ ]  |
| **Telephone No.:** |  |
| **E-mail address:** |  |
| **Referral Pathway:*****Please tick as appropriate*** | Outcome of SPOCOutcome of Contact ReferralDuring completion of CSACompletion of CSAOutcome of 0-2 Pathway | [ ] [ ] [ ] [ ] [ ]  | Social Work Pod Discussion – Stepdown Social Work Pod Discussion – Joint WorkPITSTOP MeetingMAPLACEarly 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;**