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| Interim Early Help Assessment & Plan |
| **Name and role of professional initiating assessment:** |  | **Date initiating assessment:** |  |
| **Family Name :**  | **Given Names:**  | **Date birth :**  |
| **Primary Address:**  | **Contact phone number:**  | **NHS number (if known):**  |
| **Religion:**  | **Ethnicity:**  | **Gender:** | **Primary Language:****Interpreter required:** |
| Do you consider the child to have a disability, as defined by the Equality Act 2010?  **Y / N***If the child's name is not on the disability register, do parents’ consent to it being placed there?* **Y / N** | **Is this referral to access:*** Early Help Panel
* Parenting
* Commissioned Services
* Early help (no access to EHM)
 | **Are you the lead coordinator: Y / N** |
| **Is the child a young carer: Y / N** |
| **EHCP in place: Y / N** |
|  Details of Parents/Carers/Family |
| Name: | Address:  |
| Relationship:  | Telephone: |
| **List below any other children or adults within this family /household (Add more rows if required)**  |
| Name | Date of Birth / Age | Relationship |
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| **Services working with this child/family –** For example GP, Health visitors, School **(Add more rows if required)**  |
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| **Reason for Assessment**  |
| Brief description of current situation What are your concerns? |   |
| Has someone with parental responsibility for the child/young person, given consent to contact being made with other agencies? If consent was not sought, explain why. |  |
| Was the child/young person seen during this assessment? Were they seen alone? |  |
| Summary of child and family history, including any previous or current professional involvement |  |
| **Child/Young Person’s Health and Development** |
| *Describe the child’s lived experience from their own perspective referring to any direct work you have undertaken during the assessment. This should be included for all children being worked with. This section should (where possible) refer to the child’s understanding of the situation and their wishes and feelings about what needs to change.* |
| **Voice of the Child** |  |
| **Parents concerns for the child / young person** |  |
| **Any other support needs identified?** |
| *Please consider: Emotional wellbeing, behavior and routines, housing needs, safety, family and community, physical health, education, employment and finances and any other areas identified by the family.* |
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|  **Analysis** |
| **Lead Professionals analysis of the current situation***This will help you agree the desired outcomes and the actions needed to achieve these.*  |
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|  **Outcome Plan**  |
| **What’s Working Well?** This is where you record the good stuff! What do you/your family enjoy? Think about what you’re good at; your successes. Who makes up your support networks? | **What are you worried about?** Think about what is important to you and your family. This is where we record your concerns and what we have identified as a concern. What do you think could be better? | **What would you like to see happen?** What’s important for you and your family? What are your goals? Actions that you feel will help you and your family. | **Who is responsible for this action?****Date to be completed.** |
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| **Signatures and Comments** |
| **Child / Young person’s comments on assessment** |  |
| **Family comments on assessment** |  |
| **Name of practitioner completing assessment** |  | **Job title** |  |
| **Parents Signature** |  | **Date** |  |
| **Review Date** |  |  |  |

