# Multi Agency Support Team (MAST) Request for Support Form

If you are concerned about a child or family, use this form to get support from the team at Tower Hamlets Council and our partners.

You can expect feedback within 24 to 48 hours upon submission of this referral form. We are dedicated to actively collaborating with you and other relevant services to guarantee every child receives the necessary support.

*\*Please indicate the relevant option by placing a tick in the corresponding box.*

1. Child/Young Person

|  |  |
| --- | --- |
| **First Name** |  |
| **Last Name** |  |
| **D.O.B** |  |
| Gender | M□F □ |
| **Unborn – Y/N** |  |
| **Expected D.O.B** |  |
| **Child’s First Language** |  |
| **Is an Interpreter or Signer Required? – Y/N** |  |
| **NHS Number** |  |
| **Unique Pupil Number** |  |
| **Address** |  |
| **Postcode** |  |
| **Telephone Number** |  |
| **Email** |  |

**Child/Young Person’s Ethnicity:**

The categories below are defined by the Department of Health and Social Care (DHSC). In addition to helping us to consider the particular needs of the child/young person being referred, this information, when will allow better planning of the services.

Caribbean □ Indian □ White British □ White and Black Caribbean □ Chinese □

African □ Pakistani □ White Irish □ White and Black African □ Bangladeshi □ Any

other Black background □ Any other White background □

Any other Asian background □ Any other Mixed background □ Not given □

Any Other (please specify) □

Religion:

1. **Child/Young Person’s Principal Carers** *– Please include parents or others who have a caring role for the child/young person, siblings, and any relevant extended family members.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name** | **D.O.B** | **Relationship to Child** | **Ethnicity** | **Parental Responsibility – Y/N** | **First Language of Carers** |
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1. **Other Household Members**

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| --- | --- | --- | --- | --- |
| **Full Name** | **D.O.B** | **Relationship to Child** | **Ethnicity** | **Tick if also Referred** |
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1. **Other Significant People in the child/young persons Life, including other family members.**

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| --- | --- | --- | --- |
| **Full Name** | **Relationship to Child/Young Person** | **Address** | **Contact Details** |
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 **Has anyone in the Household ever had a Child Protection Plan?**

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| □ **Yes** | □ **No** | □ **Don’t know** |

**If ‘Yes’, please provide the details with dates and all relevant information.**

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**Referrals will be shared with the family and should not be made without their knowledge or agreement, except when doing so would endanger the safety of the child/young person.**

The child/young person knows about the referral: Y/N

**If No – State Reason below:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The parent carer knows about the referral: Y/N

**If No – State Reason below:**

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1. **Presenting Issues** – *At least one presenting issue MUST be selected. If multiple issues have been identified selected all that are applicable.*

Alcohol □ Anti-Social Behavior □ Immigration *no recourse to public funds* □ Criminal Exploitation □ Disability □ Domestic Violence □ Drugs □ Families in acute stress □ Financial Problems □ Gangs / Youth Violence □ Housing □ Health & Illness □

Child Mental Health □ Parental Mental Heath □ Missing Child □ Missing Education □

Neglect and abuse □ Parenting Support □

Additional Educational Needs (please describe briefly below) □

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Sexual Exploitation □ Trafficked Children □ Unaccompanied Minor □ Young Carer □

Other (please specify below) □

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1. **Lead Professional** (if known)

**Lead Professional Name**

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**Job Title**

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**Contact Number**

|  |
| --- |
|  |

**Email**

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1. **Services Involved**

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| --- | --- | --- |
| **Name** | **Agency** | **Contact Details** |
|  |  |  |

1. **School/Preschool Attended**

**Name**

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| --- |
|  |

**Address**

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| --- |
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**Post Code**

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1. **Referral Information** - *The purpose of this section is to support the inter-agency assessment. If you lack information about a specific area, please write ‘Not Known’ (N/K). Document both strengths and areas of need or risk to ensure resources are allocated effectively.*

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| **Worry** - *What are you most worried about? Describe your concerns for the unborn baby, infant, child/young person or family or any issues that require assistance or support.* |
|  |
| **Family Strengths** - *What is currently working well for the child and family? Share positive aspects or abilities within the family that can be further supported.* |
|  |
| **Please provide us with any further information about the child's development and any other presenting issues.** |
|  |
| **Current situation** *- How safe do you think child is? On a scale of 0 to 10 where 0 means the child is at risk of harm and 10 means the child is safe.* |
| *0 1 2 3 4 5 6 7 8 9 10*Please tell us how you reached this score? |

1. **Early Help Details** – *Early help describes any service that supports children and families as soon as problems emerge.*

**Has anyone in the household ever received support from Early Help?**

|  |  |  |
| --- | --- | --- |
| □ **Yes** | □ **No** | **□ Don’t know** |

 **Which children are or were receiving 'early help? Please tell us the name of the child, the dates they were receiving early help and any other relevant information.**

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1. **Level of Need** - *More information on level of need:* [*The Four Levels of Need*](https://www.londonsafeguardingchildrenprocedures.co.uk/thresholds.html#2.-the-four-levels-of-need)

|  |  |
| --- | --- |
| **Level 1: No Additional Needs** |  |
| **Level 2: Early Help** |  |
| **Level 3: Children with Complex Multiple Needs** |  |
| **Level 4: Children in Acute Need** |  |
| **Don't know** |  |

**Supporting Documents** - *Do you have any relevant supporting documents, like assessments or the latest review that you would like to upload?*

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| (Attach and submit the files) |

1. **Details of the person making the referral**
**Name**

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| --- |
|  |

**Organisation**

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**Job Title**

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**Contact Number**

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**Contact Email**

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**SIGNATURE OF REFERER:**

**Name of referrer:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of referrer:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of referral:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Once completed, please save, and submit by sending form to: MAST@towerhamlets.gov.uk