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| **Request for Assistance** | | | | |
| **Agency details**  (the agency completing the Request for Assistance) | **Name:**  \* | | | |
| **Address:**  \* | | | **Agency and Designation:**  \* |
| **Tel No:**  \* |
| **Email:** |
| **Fax:** |
| **Child for whom you are requesting assistance** | | | | |
| **Name:**  (including Forename and Surname)  \* | **Home Address:**  \* | **Current Address:** | | **DOB:**  \* |
| **Unique Identifier:** |
| **CHI:**  \* |
| **SEEMIS:**  \* |
| **SWIS:** |
| **Name of Establishment attended:** | | **Contact Person:** | | **Person’s Contact Details:** |
| **Is this child/young person looked after or looked after and accommodated?** | | Child Protection concerns -  Family/Social Concerns - | | |
| **Please advise of any communication needs, e.g. English as an additional language/hearing impairment** | | Interpreter Service - | | |
| **Family Details** | | | | |
| **Parent 1** | **Name:**  \* | | **Address:**  \* | **Unique Identifier:** |
| **DOB:** |
| **Parent 2** | **Name:**  \* | | **Address:**  \* | **Unique Identifier:** |
| **DOB:** |
| **Other Carer 1** | **Name:** | | **Address:** | **Unique Identifier:** |
| **DOB:** |
| **Other Carer 2** | **Name:** | | **Address:** | **Unique Identifier:** |
| **DOB:** |

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| **Please advise which service/agency or professional you are requesting assistance from and give details of your specific request.** |
| Integrated Community Childrens Nursing Service -Please specifiy which service you require - |
| **If you are aware of any previous requests for assistance, please provide details below and any outcomes you are aware of.** |
| Does the child or young person have any other condition for which they require additional support (e.g. ADHD, ASD, Learning Disability)? |
| **Summarise your current concerns, including child’s views and parents’ views, if known, and any other information relating to child’s circumstances. (Attach any single agency assessment/plans/chronologies)** |
| In this section please specify in detail -  Medical /Health Problems as well as significant past history:  Description of nursing need:  Current Medication:  Supplies provided (including 7 day supply):  Training Requirements for Parents/Carers:  Referring Consultant as point of contact:  All relevant information is required to enable the patient to be seen by the correct service in a timely manner. Good referral information will assist in this process. If incomplete or inadequate referral information is forwarded, this may result in the referral being returned to the referrer, which will cause delays to treatment.  Child/Young Person will be contacted within 48 hours of receipt of referral unless otherwise stipulated by referer: |
| **What are the family, you or your agency currently doing to support this child?** |
| Discharge date:  Date of expected contact: |
| **Are you aware of actions from any other agency, being taken to support child/family currently, or in the past?** |
| Social Work involvement:  3rd sector agencies: |
| **What do you consider another professional can do to help the child’s wellbeing?** |
| To empower and support parent/carer to meet needs of child at home  ICCNS to facilate and support training to meet the health needs of their child/young person  What matters to me? (programme) |

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| **What difference to the child’s well-being is the practitioner (requesting assistance) hoping to achieve? In addition to these short term outcomes please describe long term outcomes.** | | | |
| To meet the nursing needs of the child/young person within a community setting | | | |
| **Has informed consent been given to share information with other agencies? This relates to the Lanarkshire Information Sharing Protocol and consent form.** | | **Yes** | |
| **No** | |
| **Is the Named Person aware of the Request for Assistance?** | | **Yes** | **No** |
| **Is the Lead Professional aware of Request for Assistance (where applicable)?** | | **Yes** | **No** |
| **Named Person details** | **Name:** | | |
| **Address:** | | |
| **Agency and Designation:** | | |
| **Tel No:** | | |
| **Email:** | | |
| **Fax:** | | |
| **Lead Professional details** | **Name:** | | |
| **Address:** | | |
| **Agency and Designation:** | | |
| **Tel No:** | | |
| **Email:** | | |
| **Fax:** | | |
| **Date form completed:** |  | | |