**Early Help Assessment** 

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family details** |  |  |  |  |  |  |
| **Details of all subject child(ren)** |  |  |  |  |  |  |
| **Name** | **DOB / EDD** | **Gender** |  | **Disability** |  | **Address** |  |  | **Ethnicity** | **Religion** |
|   |   |   |   |  |  |   |  |   |  |   |
| **Family / household members** |  |  |  |  |  |  |
| **Name** | **DOB / EDD** | **Gender** |  |  | **PR** |  | **Ethnicity** |  | **Religion** |  | **Relationship** |
|   |   |   |   |  |  |   |  |   |  |  |   |
| **Other significant people not living in the household** |  |  |  |  |  |  |
| **Name** | **DOB / EDD** | **Gender** | **PR** |  | **Address** | **Ethnicity** |  | **Religion** | **Relationship** |
|   |   |   |   |   |   |   |   |

This should address the communication needs of all the people who are named above

Equality, diversity and communication needs (including language) regarding any of the people to be included in this assessment

This should address the legal status / immigration status of all the people named above

Legal status/immigration status information regarding any of the people to be included in this assessment

# Assessment information

**Has this assessment been completed?**

Yes

No

Why was this assessment not

completed?

Further detail

Date assessment started

Type of assessment

**Were all family members seen as part of this assessment?**

Yes

No

If not, reasons why

What has led to this assessment?

**Details of person leading this assessment**

Name and designation

Organisation

Address

Contact telephone number

**Details of Historical Referrals/Requests**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Subject(s) of referral** | **Referral/ Request made to** | **Date of Referral/Request** | **Outcome** | **Impact** |
|  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Subject(s) of referral** | **Referral/ Request made to** | **Date of Referral/Request** | **Outcome** |  | **Impact** |
|   |   |   |   |   |  |
| **Services working with this family** |  |  |  |
| **Name and designation** |  | **Telephone** |  | **Person working with** | **Contributed** |
|   |   |   |   |

# Assessment summary

**Child/Young Person - 0**

What is working well?

What are you concerned about?

Wishes and feelings

**Does the child/young person have an EHCP?**

Yes

No

Assessment in progress

**EHCP Reasons**

CDC Assessment in progress

Cognition and Learning

Social and Emotional

Communication and Interaction

Sensory/Physical

**Family**

Include family history

What is working well?

What are you worried about?

Wishes and feelings

**Community and Social Factors**

What is working well?

What are you worried about?

# Reflection and analysis

Now the assessment is completed you need to record conclusions, solutions and actions. Work with the family and take account of their ideas, solutions and goals.

For example strengths, no additional needs, additional needs, complex needs, risk of harm to self or others. What are the critical worries?

Are there any complicating factors?

For example what outcomes, solutions and goals do the family and you want to achieve.

What needs to change?

Recommendations and outline plan

What might happen if things don't improve?

Child or young person's comment on the assessment and actions identified

Parent or carer's comment on the assessment and actions identified

Date assessment completed

**Is management oversight required?**

Yes

No

**Management Oversight**

Management Oversight

Manager Signature

Has not been verified

Date Manager signed off assessment

**Family Sign-off**

Family member to sign on behalf of all persons in this assessment.

I confirm that I have been given a completed copy of the Assessment and agree with it's factual accuracy. Signature

Date

 No Signature available

No Signature available - please provide the reasons why

|  |
| --- |
| Has not been verified |

Assessor