**Checklist for Practitioners on Initial Home Visit**

Complete as appropriate to confirm that this information has been shared with you and explained:

|  |  |  |
| --- | --- | --- |
| **Information Shared with Parent/s:** | **Y/N** | **Comments** |
| Consent to share information discussed and signed. |  |  |
| Representations Procedure(Complaints or Compliments) |  |  |
| Access to Records Information |  |  |
| One Point Service Processes |  |  |
| Relevant contact numbers for your lead professional |  |  |
| DCC Smoking Policy |  |  |
| Information Shared Discussed |  |  |
| Transporting Children Policy |  |  |

|  |  |  |
| --- | --- | --- |
| **Signature of Parent (s)** | **Print Name** | **Date** |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Signature of Child/YP****(as appropriate)** | **Print Name** | **Date** |
|  |  |  |
|  |  |  |