DSPL | Developing Special Provision Locally

Be involved, make a difference

Solution Focused Triage Team DSPL9

Supporting Children, Young People & Families
In Early Years, Schools, Colleges & at Home
For Watford, Three Rivers, Bushey & Radlett

SERVICE REQUEST FORM

Guidance: IMPORTANT

The Team will consider service requests to support families, children or young people with multi-complex needs that require intensive involvement. We will initially apply a triage technique to the request and may identify a service or organisation that will meet the need. In cases where this cannot be accomplished we will endeavour to design and apply an appropriate solution. This form should be completed with the whole family in mind where appropriate. Please provide us with as much information as possible including information regarding your involvement and all previous interventions. Please note that we cannot accept referrals without family or young person consent**. If you do not have consent for this referral please consider requesting an Initial Consultation.**

We will contact you as soon as possible to discuss the case. Should you prefer to discuss this pathway please contact: Jan Crook on 07715 415894 or e-mail: **jancrook@DSPL9.org.uk** Thank you.

Service Request Details	
Name of person completing the request	
Position	
Name of Organisation:	
Address:	
Contact Number	
e-mail address	

Name and Address of Person/Family of Concern

Family Surname(s)	**Address(s)**	**1st Language**
		English Spoken Y/N
		Interpreter Required Y/N
		BSL/Makaton Y/N
Contact Number		

We will ask you for more information regarding the family /child/young person later in the form

Family Composition/ Significant Others

Full Name	Address	DOB	Relationship	M/F

Please give details of Early Years Settings, Schools, Colleges attended and Year Group

Are The Family/Person aware of this Service Request	Yes/No
Do they give their consent to this Service Request	Yes/ No
Consent given by: (Parent, Young Person)	
Full Name: (Parent)	
Signature:	
Full Name: (Young Person)	
Signature:	
If consent is not given please consider making an Initial Consultation Request	

Please give date, time and venue of any arranged meetings i.e CAF, CP/CIN, SEN
(we will contact you to confirm attendance if appropriate)

Existing and/or Historical Factors (C/YP = Child or Young Person)

	Y	N	?	Parent/Carer or C/YP Name	Additional Information
Mental Health Issues - Adult					
Mental Health Issues – C/YP					
Learning Difficulties - Adult					
Additional Needs – C/YP					
Physical Disabilities- Adult					
Physical Disabilities- C/YP					
Sensory Impairment - Adult					
Sensory Impairment - Adult					
Emotional Outbursts - Adult					
Emotional Outbursts – C/YP					
Domestic Violence					
Anti-Social Behaviour					
Child Protection Plan					
Child In Need Plan					
Common Assessment Framework					
Drug and/or Alcohol issues					
Other - please specify					

(Please provide copies of any related documents where possible)

Other Organisations, Agencies and Services involved (past and present)

Organisation	Contact Person	phone or e-mail	Current Yes/No
G.P			
Adult Mental Health Team			
Child & Adolescent Mental Health			
Social Care			
Integrated Services for Learning i.e			
(EP,AIO,SEN,Early Years etc).			
School-based Family Workers			
Thriving Families			
Targeted Youth Support Team			
Youth Offending Team			
Disabilities Team - Adult			
Probation			
Drug & Alcohol Service			
other - please specify			

Please give a brief description of intervention outcomes to date
(continue on a separate sheet if required)

Please give a brief description of the desired outcomes from the Solution Focused Triage Team

Have you completed a Risk Assessment Yes/No
(please attach a copy if available)
Have you identified any risk attached to working with this family/child/young person? Yes/No
Please provide any relevant details:

Service Request signed by _____ (Print name) _____(signature)

Date: _____

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