When complete, please **email** this form to info@calderdalemhst.org.uk. (Note that it cannot be handed to your EMHP on paper.)

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| **FOR COMPLETION FOLLOWING AGREEMENT IN MHST SUITABILITY DISCUSSION****(Guidance is available from the MHST – please ask if unsure)** |
| **Name of School Staff member providing information:** |  |
| **Name of School:** |  |
| **Name of MHST staff member involved in suitability discussion:** |  |
| **Date of Completion:** |  |

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| **REASON FOR SUPPORT REQUEST** *(from suitability discussion)***:****Mental health support needs & concerns:**  [ ] Anxiety ☐[ ]  Low Mood ☐[ ] Exam Stress [ ] Other Click or tap here to enter text.**Known history** *inc previous support, assessments and what is working****.*** ***What the Young Person would like to change?***  |
| *This box will expand if required* |
| **Professional’s voice (names)** |
|  *This box will expand if required* |
| **Child/ Young Person Voice** *(If available. With consent)* |
| *This box will expand if required* |
| **Parent/Carers Voice** *(If available. With consent)* |
| *This box will expand if required* |

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| **SAFEGUARDING:**  | **Has the young person ever been deemed a Child in Need:**[ ] Yes Currently [ ] Yes Previously [ ] Never [ ] Not Known |
| **Has the young person ever been subject to a Child Protection Plan:**[ ] Yes Currently [ ] Yes Previously [ ] Never [ ] Not Known |
| **Has the young person / family ever had social work involvement:**[ ] Yes Currently [ ] Yes Previously [ ] Never [ ] Not Known |
| **Is there a CAF / Early Help Plan in place?:** [ ] Yes ☐[ ] No*Please Provide the Social Worker/Contacts Name:* Click or tap here to enter text.  |
| **If ‘YES’, to any of the above, please provide further details:***i.e. reason for involvement, dates / length of involvement, name and contact number of any current social workers and Local Authority responsible for providing care / professionals* |

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| **OTHER SUPPORT:** Please provide details of other services involved with YP/family: |  |
| **Current serious risk of harm to self?**  | [ ] Yes ☐[ ] No(if yes please provide further details) |

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| **MHST SUPPORT SUGGESTED IN SUITABILITY DISCUSSION** *(If known). May be more than one support type. Please be specific and use MHST staff guidance (phrases can be copied and pasted):*  |
| **Function 1: Direct Support with EMHP/MHST Practitioner inc Silvercloud (YP or parent), or Consultation** |  |
| **Function 2: Whole School Work** |  |
| **Function 3: Advice/ Liaison/ supported onward referral** |  |

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| --- |
| **Young Person:** |
| **Name:** |  |
| **Gender:** |  |
| **DOB:** |  |
| **Year Group:** |  |
| **Ethnicity:** |  |
| **Address:** |  |
| **GP Surgery:** |  |
| **YP email *(for S/C if relevant):*** |  |
| **YP mobile number *(if relevant):*** |  |

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| --- | --- | --- |
| **PARENT/CARERS** | **Parent/Carer 1:** | **Parent/Carer 2** *(if relevant)***:** |
| **Name:** |  |  |
| **Relationship to YP:** |  |  |
| **Email:** |  |  |
| **Mobile no:** |  |  |

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| **INCLUSION INFORMATION:** | **Yes** | **No** |
| **Child Looked After:** |  |  |
| **SEN Support:** |  |  |
| **EHCP:** |  |  |
| **Impact of flooding on mental health:** |  |  |
| **Risk of Exclusion:** |  |  |
| **Disability:** |  |  |
| **Disability details *(if relevant)*** |  |

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| --- | --- |
| **CONSENT:** Tick to confirm that parent/carer(s) have given consent for this Request for Support to be shared | [ ] Yes  |

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