# LIFT (Local Integrated Family Team)

01824 706106

**We can only accept referrals where consent has been obtained from the parent or a person with parental responsibility.**

**This referral is for:**

**LIFT**

# LIFT can provide advice and signposting, specialist consultation, assessment, formulation, and intervention for:

* Challenging behaviour that occurs in the home.
* The behaviour is NOT occurring in the context of a learning disability.
* The Child is not open or actively working with other specialist teams.

**Disability Wellbeing Navigator (Denbighshire ONLY)**

DWN can provide information, advice and assistance to families who have a child or young person (0-25) with an additional need or disability to liaise/access appropriate support from education, healthcare, and social care professionals and from the voluntary sector.

**The referral and supporting documents can be emailed to:**

[LIFT@denbighshire.gov.uk](mailto:LIFT@denbighshire.gov.uk)

**For full details of how we use your data please visit** [**www.denbighshire.gov.uk/en/privacy/privacy.aspx**](http://www.denbighshire.gov.uk/en/privacy/privacy.aspx)

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| **Referrer Details** | |
| **Name:** | **Relationship to child:** |
| **Date of online contact form:** | **Contact Telephone:**  **Contact Email:** |
| **Professional:**  **LIFT Team member:**  **Date referral form completed:** | |

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| **Child’s Home Address & Parent/Carer Contact Details** | |
| Home address & postcode |  |
| Contact telephone number(s) | Mobile:  Landline: |
| Email address |  |
| Preferred contact time |  |
| Preferred method of contact | Phone Text/WhatsApp Email Post |

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| **Child’s Personal Details** | | | |
| Full name |  | | |
| Date of Birth |  | | |
| Gender |  | Ethnicity |  |
| Preferred language | English / Welsh / Other | If Other, please state |  |

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| **Parental consent** | | | | |
| **Full Name of parent(s) / person(s) with parental responsibility:** | | **Full Name of parent(s) / person(s) with parental responsibility:** | | |
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| **Have they given their consent to the referral being made to the Service?** | YES  NO | **Have they given their consent to the referral being made to the Service?** | | YES  NO |
| **By giving consent, you agree for our team to request and share information regarding the child(ren) with agencies supporting the family in order to deliver our service.** | | | | YES  NO |
| **Child / young person’s consent** | | | | |
| **Has the child / young person consented to the referral being made to the Service?** | | | YES  NO | |
| **If child refuses or is unable to give consent, please provide details:** | | | | |

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| **Details of Persons living in Child’s Household** | | | | |
| Name | Relationship to child/young person | Date of Birth | Has Parental Responsibility?  Y/N | Disability/Mental Health |
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| **Significant Others – Not in Household**  (Please list any significant others who are not listed in the household section above) | | | | |
| Name | Relationship to child/young person | Date of Birth | Has Parental Responsibility?  Y/N | Disability/Mental Health |
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**Please give details of the child’s GP, Health Visitor, School Nurse, Paediatrician and any known health conditions or diagnosis. Please include the most recent health or clinic letters.**

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| **Details -**  GP Name:  GP Address:  GP Contact Number:  **Other -**  **Child’s health conditions or diagnosis –** |

**Is the child on a waiting list or currently working with any other children’s services?**

**Have they previously been known to any services?**

**Please provide the relevant reports; we cannot decide eligibility without this information.**

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|  | Early Years Nursing Team |  | Family Wellbeing Service |
|  | Child and Adolescent Learning Disability Service (CALDS) |  | Speech and Language  Occupational Therapy |
|  | CAMHS |  | Physiotherapy |
|  | Sleep Clinic |  | Paediatrician |
|  | Neurodevelopmental Services |  | Other |

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| **Please give further details of service input:** |

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| **Which school do they attend?** | Primary  Secondary  Special  Educated at home |
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| **Details:**  School:  Year:  **Who would be the best person to contact? (Teacher/Head of Year/ALNCo)**  Contact information: | |

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| **Are they receiving any additional support at school?** |  | Yes |  | No |
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| **Details:** | | | | |

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| **Social Care**   |  |  | | --- | --- | | * Is the child/family under social services or have they been previously? * Is the child/family under any child protection services or have they been previously? * Does the child/family have any other social care teams involved or have they been previously? | YES  NO  YES  NO  YES  NO |   **If you answered Yes to any of the above, please add details below:** |
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| Details: |

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| **What matters to the child?**  **What matters to the parent(s)/carer(s)/family?**  **What is the child/parent(s)/carer(s)/family’s strengths? What is currently working well?**    **What are the barriers that prevent the child, parent(s)/carer(s) achieving what matters to them?**  (e.g. significant life events, changes, stresses, bereavement, mental health concerns)  **What are the risks if the child, parent(s)/carer(s) don’t achieve what matters to them?**  **Have the family accessed any of the following services?**   |  |  |  | | --- | --- | --- | | **Courses** | **Voluntary Services** | **Early Help Services** | | Solihull Online  Solihull Face to Face  Incredible Years  Nurturing Programme  Living with teenagers  Talking Teens  NVR – Non Violence Resistance  Cygnet  Early Bird  Other | Integrated Autism Service  STAND NW  Barnardo’s  WCD Young Carers  NEWCIS  Other | Conwy Family Centres  Flying Start  Families First  Team around the family (TAF)  Family Link Workers  Other | | **What worked well? What didn’t work well?** | | |   **What are your main concerns around the challenging behaviour?**  **Details:**   * **Challenging behaviour:** * **Physical aggression –** * **Verbal aggression –** * **Self-injurious behaviour –** * **Disruptive behaviour –** * **Sexually inappropriate behaviour –** * **Property destruction –** |

* **Sleep pattern –**
* **Eating Pattern –**
* **Relationships –**
* **Peer relationships –**
* **Sensory concerns –**
* **Stereotypic/Repetitive behaviour –**
* **Motivation –**
* **School attendance –**
* **Substance misuse –**
* **Self-harm –**

**Other –**

LEASE COMPLETE

**Children and Young People’s CPG**

**Lone Worker Checklist**

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| **Section A – Risk identified prior to home visit** | | |
| **Hazard/Risk Factor** | **Comments/Actions** | **Date and Signature** |
| Location/isolated area |  |  |
| Access difficult |  |  |
| Animals |  |  |
| Violence/Domestic violence |  |  |
| Substance abuse |  |  |
| Child protection/family issues |  |  |
| Social services involvement |  |  |
| Any other risk |  |  |

**Note: If the assessment identifies significant risk, visits alone will not be permitted (See lone worker policy)**

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| **Section B – Identified risk post home visit** | | |
| **Hazard/Risk Factor** | **Comments/Actions** | **Date and Signature** |
| Building conditions |  |  |
| Communication difficulties e.g., mobile phone signal |  |  |
| Any other risk factors (please list) |  |  |

**This check list should be placed in the individual’s file for access. If the individual circumstances/and or environment/location changes the assessment needs to be reviewed.**

**A full risk assessment should be completed as/if required**  [Risk Assessment Form](http://howis.wales.nhs.uk/sitesplus/861/document/299808)[Risk Assessment Form](http://howis.wales.nhs.uk/sitesplus/861/opendoc/299808)