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| **Early Help Assessment (EHAF) Registration Form**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Please complete this information to register all early help assessments (not referrals)** | | | | | | **Name of referrer:** |  | | | | | **Contact details of referrer:** | **Telephone number:** | | | | |  | **Email address:** | | | | |  | **Work base i.e. name of school, team or children’s Centre:** | | | | | **Organisation registering EHAF:** | Choose an item. | | | | | **Name of Child / Young Person:** |  | | | | | **Date of Birth:** | **Current age:** | | **Unborn:** Choose an item. | | | **Ethnicity:** Choose an item. | **Disability:** Choose an item. | | | | **Address:** | **Post Code:** | | | | **Telephone number:** | | | | **Evidence of consent provided on referral form or verbally by referee**: | | Choose an item. | | | **Pathway to Provision level on initiation** | | Choose an item. | | | **Main presenting reason for the child or young person:** | | Choose an item. | | | **Main presenting reason for the parent/carer:** | | Choose an item. | | | **Main presenting reason for the family:** | | Choose an item. | | | **Involvement with Children's Social Care** | | Choose an item. | |  |  | | --- | | **Information required for EHAF only** | | **Date assessment initiated:** | | **Date assessment completed:** |  | **Lead Professional details for EHAF:** | | | --- | --- | | **Name:** | **Role:** | | **Service:** | **Base:** | | **Telephone number:** | **E-mail address:** | | **Start date:** | **End date:** | |