

# Targeted Early Help Assessment

## 1. PRACTITIONER INFORMATION

Practitioner agency/service	Date Completed
Practitioner name	Practitioner telephone
Practitioner email	

## 2. FAMILY INFORMATION

PARENT / CARER 1		PARENT / CARER 2	
Name		Name	
Parental responsibility?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Parental responsibility?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone		Telephone	
Date of birth		Date of birth	
Ethnicity		Ethnicity	
Address and postcode		Address and Postcode	
Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>
Health needs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Health needs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Special Educational Needs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Special Educational Needs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Communication support needs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Communication support needs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Immigration Status		Immigration Status	

CHILD / YOUNG PERSON		Gender	Disability	Special Educational Needs	Health Need
Child / Young Person 1	Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Date of Birth:				
	Ethnicity:				
	Address				
	Name of early education / school /college				
Child / Young Person 2	Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Date of Birth:				
	Ethnicity:				
	Address				
	Name of early education / school /college				
Child / Young Person 3	Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Date of Birth:				
	Ethnicity:				
	Address				
	Name of early education / school /college				
Child / Young Person 4	Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Date of Birth:				
	Ethnicity:				
	Address				
	Name of early education / school /college				



## 5. INFORMATION GATHERING

### What is currently working well for the family

What does the child, young person like / do well?  
 What do the family say works well for them or has done in the past?  
 Do the family have a support network (family, friends, professionals)? If so what does this look like?  
 What are the views of the child/young person and/or family?

**DEVELOPMENT OF  
BABY/CHILD/YOUNG PERSON**

**PARENTAL FACTORS**

**ENVIRONMENTAL & FAMILIAL  
FACTORS**

### What are you or the family are worried about

What is making you feel concerned/worried?  
 What is making the family feel concerned/worried?  
 What is the impact on the child or young person?  
 What are you worried would happen if nothing changes for the child / family?  
 What are the views of the child/young person and/or family?

**DEVELOPMENT OF  
BABY/CHILD/YOUNG PERSON**

**PARENTAL FACTORS**

**ENVIRONMENTAL & FAMILIAL  
FACTORS**

### What change needs to happen to make things better?

How can the family be supported to make change?  
 What do the family think would support them to make things better?  
 What support do you think is needed to make things better?  
 What services / support would the family need to achieve these positive changes?  
 What are the views of the child/young person and/or family?

## 6. ANALYSIS

Worry Statement:

Well-being Statement:

Wellbeing scale: 1-10

**7. FAMILY PLAN, following on from assessment**

Family Goal	What needs to be done	By Whom	By When	Review / Update

**9. PARENT / CARER VIEWS**

Use this space for the family to share their views

**10. CHILD / YOUNG PERSON VIEWS**

Use this space for the child / young person to share their views

Signing below confirms consent for the information in this plan to be stored in accordance with the organisations data protection, privacy and GDPR policies and will be shared with those working alongside the family.

**11. CONSENT**

Parent signature		Date:	Click to enter a date
Parent Signature		Date:	Click to enter a date
Child/young person		Date:	Click to enter a date
Child/young person		Date:	Click to enter a date