



Tri Borough Emergency Duty Team Tel: 02087085897

MULTI - AGENCY REFERRAL FORM

This form to be used by all agencies referring children/young person to Children's Social Care services for assessment as a child in need, in need of protection and /or children and young people that are being privately fostered.

All urgent referrals should be initiated by phone/email/fax and followed up in writing within 24 hours, by completion of as much of this form as possible (Please PRINT clearly). For the efficiency of processing referrals please fill in a digital referral and email it to the above address.

A. CHILD/YOUNG PERSON

Child/Young Person's ethnicity:				
The categories below are defined by the Department of Health. In addition to helping us to consider the particular needs of the child/young person being referred, this information, when will allow better planning of the services.				
Caribbean <input type="checkbox"/>	Indian <input type="checkbox"/>	White British <input type="checkbox"/>	White and Black Caribbean <input type="checkbox"/>	Chinese <input type="checkbox"/>
African <input type="checkbox"/>	Pakistani <input type="checkbox"/>	White Irish <input type="checkbox"/>	White and Black African <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>
Any other Black background <input type="checkbox"/>	Any other White background <input type="checkbox"/>	Any other Asian background <input type="checkbox"/>	Any other Mixed background <input type="checkbox"/>	Not given <input type="checkbox"/>
Any Other (please specify) <input type="checkbox"/>				
Religion:				

Family Name			Forenames		
D.O.B		M <input type="checkbox"/> F <input type="checkbox"/>	Unborn M/F	Expected D.O.B	
Child's First Language			Is an Interpreter or Signer Required?	Y / N	
Responsible Local Authority			Child/Young Person known to be in care of another Local Authority		
Address					
Postcode			Tel.		
Current address if different from above					
Postcode			Tel.		

B. CHILD/YOUNG PERSON'S PRINCIPAL CARERS.**(Please consider if the child/young person is being privately fostered)**

FULL NAME	DOB	RELATIONSHIP TO CHILD	ETHNICITY	PARENTAL RESPONSIBILITY
				Y / N
				Y / N
				Y / N
First Language of Carers:			Is an interpreter or signer required: Y / N	

C. OTHER HOUSEHOLD MEMBERS

FULL NAME	DOB	RELATIONSHIP TO CHILD/YOUNG PERSON	ETHNICITY	TICK IF ALSO REFERRED

D. OTHER SIGNIFICANT PEOPLE IN THE CHILD/YOUNG PERSONS LIFE, INCLUDING OTHER FAMILY MEMBERS.

FULL NAME	RELATIONSHIP TO CHILD/YOUNG PERSON	ADDRESS	TEL. NO.

REFERRALS WILL BE SHARED WITH THE FAMILY AND SHOULD NOT BE MADE WITHOUT THEIR KNOWLEDGE/AGREEMENT UNLESS THIS WOULD JEOPARDISE THE CHILD/YOUNG PERSONS SAFETY.

	Yes/No	If No, State Reason.
The child/young person knows about the referral.		
The parent carer knows about the referral.		

REASON FOR REFERRAL/REQUEST FOR SERVICES

If an allegation of possible physical abuse, please give specific details of any injury including dates and explanation given.

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F. INFORMATION ON STATUTORY STATUS

	Y/N	Please give details of name of child/young persons, dates, category. (if known)
Any child in family is/has been subject to a child protection plan?		
Any child or other family member is/has been looked after by a local authority?		
Any child in the family had/has a statement of educational needs (SEN)?		
Any child in the family is/has been on the disability register?		

G. KEY AGENCIES INVOLVED

Insert name of professional if involved.	Tel.	Insert name of professional if involved.	Tel.
H.V		G.P	
Nursery		EWO	
School		Police	
YOT		Midwife	
Community Mental Health		Community Paediatrician	
School Nurse		Other	

H. INFORMATION SUPPORTING THIS REFERRAL

The purpose of this section is to assist the inter-agency assessment. Where you have no information about a particular area please write N/K. Record strengths as well as areas of need or risk so that resources can be directed appropriately.

Child/Young person's development needs and identified risk factors:

Consider health, emotional and behavioural development, education, identity, family and social relationships, social presentation and self care.

Risk Indicators:

Drug and/or alcohol misuse

Mental Health Issues

Domestic Violence

Other.....

Parents/Carers capacities to respond to child/young person.

Consider basic care, ensuring safety, emotional warmth, stimulation, provision of guidance and boundaries, and stability.

Issues affecting parent/carers capacity to respond appropriately to child/young person's needs.

Family and environmental factors which impact on the child.

Consider family history and functioning, the wider family, housing, employment, income, the family's social integration and the availability of community resources to provide support.

Risks/Hazards – Please record any issues which may present a risk to others i.e violence, aggressive dogs etc

Name of worker completing this referral. (Please Print)			
Position/Title			
Agency			
Address			
Telephone Number	FAX:		
E-mail			
Signature		Date	
Signature of manager <i>*if applicable</i>		Date	

Name of social worker taking referral			
Team		Date	