

Fax to: 020 8227 3951
Post: Assessment Team
127 Ripple Road, Barking
Essex, IG11 7PB
PH: 020 8227 3852

Fax to: 01708 433375
Post: Duty & Referral Team
16 Marks Rd, Romford
Essex
PH: 01708 433222

Fax to: 020 8708 5352
Post: Redbridge Direct
497-499 Ley St, Ilford
Essex, IG2 7QX
PH: 020 8554 5000

Multi – Agency Referral Form

This form is to be used by all agencies referring a child/young person to Children's Services for assessment as a child in need, including in need of protection.

All urgent referrals should be initiated by phone/fax and followed up in writing within 24 hours by completion of as much of this form as possible. (Please PRINT clearly and ensure that the family name is on the top of each sheet.)

A. CHILD/YOUNG PERSON

Child / Young Person's Ethnicity							
The categories below are defined by the Department for Education and Skills. In addition to helping us to consider the particular needs of the child / young person being referred, this information will allow better planning of our services.							
White British	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>
Any other white background (please specify)	<input type="checkbox"/>	Any other Black background (please specify)	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>
		Chinese	<input type="checkbox"/>	Any other Asian background (please specify)	<input type="checkbox"/>	Any other mixed background (please specify)	<input type="checkbox"/>
Not stated	<input type="checkbox"/>	Any other ethnic group (please specify)					
Religion							

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

SURNAME	
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B. CHILD / YOUNG PERSON'S PRINCIPAL CARERS

Full Name	D.O.B	Relationship to child	Ethnicity	Parental Responsibility
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Is an interpreter or signer required?
First Language of Carers				Y <input type="checkbox"/> N <input type="checkbox"/>

C. OTHER HOUSEHOLD MEMBERS (*NOTE: If an entire family is being referred, in the first instance the referral will be logged on the youngest sibling.)

Full Name	D.O.B.	Relationship to child	Ethnicity	Also being referred?
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>

D. OTHER SIGNIFICANT PEOPLE IN THE CHILD/YOUNG PERSON'S LIFE, INCLUDING OTHER FAMILY MEMBERS.

Full Name	Relationship to child	Address	Telephone

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

		If No, State reason
The child / young person knows about the referral	Y <input type="checkbox"/> N <input type="checkbox"/>	
The Parent / carer knows about the referral	Y <input type="checkbox"/> N <input type="checkbox"/>	
The Parent / carer agrees with the referral	Y <input type="checkbox"/> N <input type="checkbox"/>	

E. REASON FOR REFERRAL / REQUEST FOR SERVICES

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

SURNAME	
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F. INFORMATION ON STATUTORY STATUS

Please give details of name of child/young person, dates, category (if known).

Any child in family is/has been on the child protection register (CPR)?	Y <input type="checkbox"/> N <input type="checkbox"/>	
Any child or other family member is/has been looked after by a local authority?	Y <input type="checkbox"/> N <input type="checkbox"/>	
Any child in the family had/has a statement of educational needs (SEN)?	Y <input type="checkbox"/> N <input type="checkbox"/>	
Any child in the family has a disability?	Y <input type="checkbox"/> N <input type="checkbox"/>	

G. KEY AGENCIES INVOLVED

Insert name of professional if involved	Telephone No.	Insert name of professional if involved	Telephone No.
Health Visitor		General Practitioner	
Nursery		Police	
School		Midwife	
Youth Offending Officer		Education Welfare Officer, Access & Attendance Officer	
Community Mental Health		Probation	
School Nurse		Other	
Community Pediatrician			

H. INFORMATION SUPPORTING THE REFERRAL

Please ensure you distinguish between fact and opinion when completing the section below. The purpose of this section is to assist the inter-agency assessment. Where you have no information about a particular area, please 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.

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Risk Indicators:

Drug and/or alcohol misuse

Mental Health Issues

Domestic Violence

Other

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

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

Issues affecting parent/carer's capability 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.

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

SURNAME	
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Name or worker completing this referral (Please Print)			
Position / Title			
Agency			
Address			
Telephone Number		Fax	
Email			
Signature		Date	

Signature of manager *if applicable		Date	
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Name of Social Worker taking referral			
Team		Date	

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Multi – Agency Referral Form Confirmation

Responsible Authority _____

Referrer Details

To _____
Title/Position _____
Address _____

Fax No _____
Email _____
Date _____
Received _____
Date _____

This is to notify you that your referral has been received on the child / young person / family below.

Name of child / young person / family referred _____

Decision of Referral	
Section 47 investigation	<input type="checkbox"/>
Initial Assessment	<input type="checkbox"/>
Core Assessment	<input type="checkbox"/>

Or

Reason for No Further Action (NFA) on referral:

Referral Status	
Awaiting Allocation	<input type="checkbox"/>
Allocated to Social Worker	<input type="checkbox"/>
Held on Duty	<input type="checkbox"/>

Signed _____
 Name _____
 Position / Title _____
 Team _____
 Date _____