

CHILDREN AND FAMILIES

Inter-Agency Referral

- If you have identified that a child / young person is in need of services you should complete a Common Assessment Framework, use this form if you are signposting or consider the child / young person is at risk.

The completion of this form is not a pre-requisite of a referral. Urgent referrals (cases where children are in need of protection or immediate action is required to prevent significant harm) should be made directly, however the Framework for the Assessment of Children in Need requires that referrals are made in writing.

NAME OF WORKER COMPLETING REFERRAL					
DATE		TIME		Agency	
TEL NO.				Contact Address	

CHILD / YOUNG PERSON'S DETAILS	Family Make-up	Adults	Children
FAMILY NAME			FIRST NAMES
DOB			GENDER
ETHNICITY			
ADDRESS OF CARER WITH PARENTAL RESPONSIBILITY			
POST CODE		TEL NO	
CURRENT ADDRESS OF CHILD	(If different)		
First Language		Religion	
Country of Birth		Immigration Status	
Home Office No.			
Alternative Method of Communication?			
Interpreter Required?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Details:
Previously known?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Details:
Is the Parent / Carer aware?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have they given consent to contact with Social Care & Health?			YES <input type="checkbox"/>
If this has not been obtained, give reasons for this, particularly why their wishes have been overruled.			NO <input type="checkbox"/>
Is the Child / Young Person aware?			YES <input type="checkbox"/>
			NO <input type="checkbox"/>

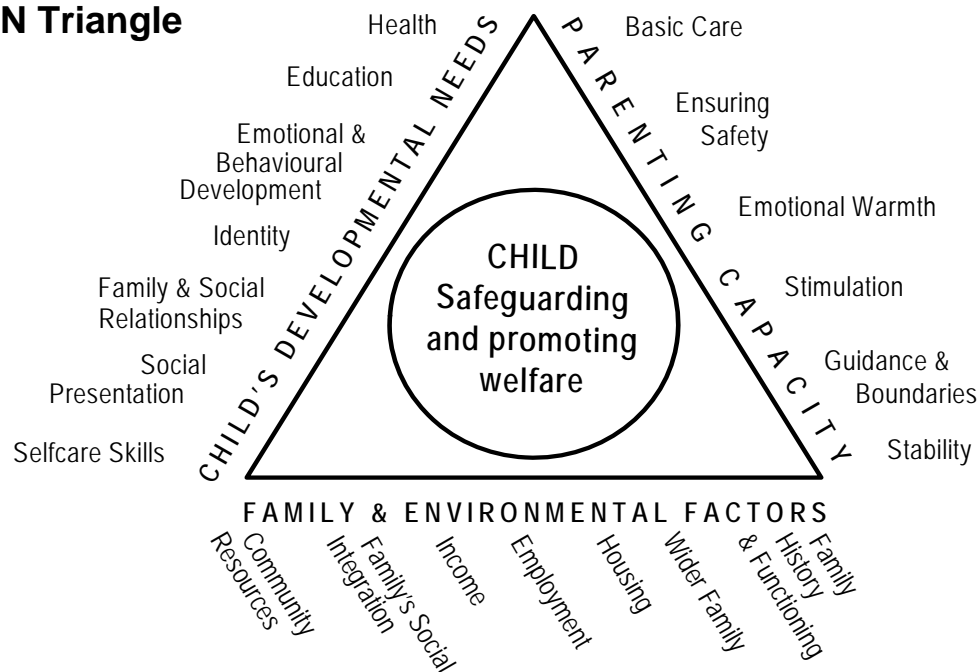
Name:

OTHER HOUSEHOLD MEMBERS (INC NON-FAMILY)			
NAME			
ETHNICITY		DOB	
RELATIONSHIP		CONTACT NO	
NAME			
ETHNICITY		DOB	
RELATIONSHIP		CONTACT NO	
NAME			
ETHNICITY		DOB	
RELATIONSHIP		CONTACT NO	
NAME			
ETHNICITY		DOB	
RELATIONSHIP		CONTACT NO	
EDUCATION – REFERRED CHILD		IS CHILD OF SCHOOL AGE?	YES <input type="checkbox"/> NO <input type="checkbox"/>
SCHOOL ATTENDED			
ADDRESS			
FORM TEACHER'S NAME		TEL NO	
EDUCATION – SIBLINGS		N/A	<input type="checkbox"/>
NAME OF CHILD	SCHOOL ATTENDED	ADDRESS	TEL NO

KEY AGENCIES/CONTACTS			
AGENCY	CONTACT NAME	ADDRESS	TEL NO
GP			

Name: _____

FACIN Triangle



NATURE OF REQUEST/REFERRAL

- Summarise the key concerns arising from the information gathered by yourself/your agency in relation to the dimensions above. Why are you contacting Children's Services at this point.

Name:

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Supporting Information attached?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Details:
Supporting Information to follow?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Details:
Signature / Print Name			Date

Name:

ADDITIONAL INFORMATION

- Please state the question you are providing additional information for: