

# Inter Agency Referral, Children In Need / Child Protection

THIS FORM MUST BE USED FOR REFERRALS OF A CHILD TO SOCIAL SERVICES WHEN THERE ARE CONCERNS ABOUT A CHILD'S WELFARE OR SAFETY, OR WHEN REQUESTING A SERVICE. IF THERE ARE IMMEDIATE CONCERNS FOR THE CHILD'S SAFETY OR WELLBEING A TELEPHONE REFERRAL MUST BE MADE TO THE CONTACT AND ASSESSMENT SERVICE. IF THE REFERRAL RELATES TO MORE THAN ONE CHILD PLEASE ENSURE INFORMATION IS INCLUDED ON ALL RELEVANT CHILDREN. PLEASE COMPLETE THIS FORM WITHIN 48 HOURS OF MAKING A TELEPHONE REFERRAL.

IF YOU DO NOT HAVE ANY RELEVANT INFORMATION FOR SPECIFIC SECTIONS PLEASE INDICATE.

### Family Composition (including unborn baby)

Child/Young Person Family Name:	First Name:	Gender:	Date of Birth:	Ethnic Code:	School/Nursery:

Home Address:

### Parents / Carers – please indicate who has Parental Responsibility (PR) for the child/ren

Family Name:	First Name:	D.O.B	Relationship to child	Parental Responsibility YES / NO	Ethnic Code (see below)

### Who are the best points of contact for the family, when is the best time to reach them, and how can they be contacted?

Name:	Relationship to child:	Address (if different from above):	Contact number:	Best times:

Ethnic codes: (NB These codes are based on 2001 census. If the codes used by your organisation are different, please use your organisation's codes instead)

A White British	D Mixed White/Black Caribbean	H Asian/Asian British Indian	M Black/Black British Caribbean	R Chinese
B White Irish	E Mixed White/Black African	J Asian/Asian British Pakistani	N Black/Black British African	S Any other
C Any other White	F Mixed White/Asian	K Asian/Asian British Bangladeshi	P Any other Black	Z Not stated
	G Any other Mixed	L Any other Asian		

Religion:	First Language:	Interpreter Required?	Written Material Needs Translating?	Literacy Assistance required?

### Reason for the referral:

1. Mother has disclosed Domestic Violence whilst attending WIC
2. Mother has agreed to this referral to SSD/ Mother HAS NOT agreed to referral. (delete as appropriate)
3. Has mother accepted referral to ADVANCE?
4. Do family already have a SW allocated to them/ if yes – Name of SW: \_\_\_\_\_
5. Name of health visitor: \_\_\_\_\_
6. Perpetrator living at same address/ Perpetrator not as same address. (delete as appropriate)
7. is it safe for SW to send details of support available, in the post? Y/N
8. If No, contact Number: \_\_\_\_\_
9. Perpetrators Name & DOB: \_\_\_\_\_

Does the Child / Young Person have a Disability / Special Needs?	If YES Please attach detailed information
Does the Parent / Carer have a Disability / Special Needs?	

**Significant others not living at home address:**

Name:	D.O.B	Relationship:	Address:

**Other Agencies involved:**

GP:	Address:	Telephone Number:

Agency:	Contact Name:	Telephone Number:	Work Undertaken:

**ASSESSMENT**

**1 Child’s development needs.** This includes health, education, identity, self-care skills, social presentation, family & social relationships and emotional & behavioural development:

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**2 Parenting capacity.** This includes basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries, stability and any issues likely to effect parenting capacity:

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**3 Family and social environment factors.** This includes community resources, family’s social integration, income, employment, housing, wider family history and functioning:

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**Is the Family / Young Person aware of the referral?**

**Date Discussed?**

**Referrer’s Name:**

**Signed:**

**Agency:**

**Address:**

**Telephone Number:**

**Date of Telephone referral:**

**Date:**

**CC: As agreed within individual agencies**

PLEASE ENSURE YOU ALSO COPY YOUR COMPLETED REFERRAL FORM TO RELEVANT PROFESSIONALS AS AGREED WITHIN YOUR AGENCY

Hammersmith & Fulham Children’s Services – Contact and Assessment Service

Floor 4

77 Glenthorne rd

LONDON W6 0LJ

TEL 020 8753 5392

FAX 020 8753 5880

## Referral Feedback Sheet

<b>Referrer's Name:</b>
<b>Agency:</b>
<b>Address:</b>

Date of referral:

Name of Child	Address

*Thank you for your referral (please tick as appropriate):*

- 1. No Further Action Needed – Case closed
  
- 2. Undertake an Initial Assessment
  
- 3. Undertake a Child Protection (Section 47) Enquiry

<b>Comments:</b>

<b>Signature of Worker:</b>
<b>Print Name:</b>
<b>Date:</b>

***When a worker is allocated they will be in contact with you. Please let us know if you have further concern about the family or you wish to discuss the action taken.***

Hammersmith & Fulham Children's Services  
 Contact and Assessment Service  
 Floor 4  
 Glenthorne Road  
 London W6 OLJ  
 Tel no 020 8753 5392  
 Fax no 020 8753 5880