

INTER-AGENCY REFERRAL FORM

This form is to be used by all agencies referring a child/children to social services for assessment as a child in need, including in need of protection.

When completing referral form use guidelines on back page.

All urgent referrals should be initiated by phone/fax and followed up in writing within 48 hours, by completion of as much of this form as possible.

A. CHILD/YOUNG PERSON

Family Name		Forename/s	
DOB/EDD	M <input type="checkbox"/> F <input type="checkbox"/>	*Ethnicity code	Religion
Child's first language		Is an interpreter or signer required?	Y / N
Address			
Postcode		Tel.	
Current address if different from above			
Postcode		Tel.	

***ONS Ethnicity Codes:** White British 1a; White Irish 1b; White other 1c; White & Black Caribbean 2a; White & Black African 2b; White & Asian 2c; Other Mixed 2d; Indian 3a; Pakistani 3b; Bangladeshi 3c; Other Asian 3d; Caribbean 4a; African 4b; Other Black 4c; Chinese 5a; Other ethnic group 5b.

B. CHILD/YOUNG PERSONS'S PRINCIPAL CARERS

FULL NAME	DOB If known	Relationship to child	Ethnicity code	Parental responsibility
				Y / N
				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 If known	Relationship to child/ young person	Ethnicity code	Tick if also referred

D. OTHER SIGNIFICANT PEOPLE IN THE CHILD/YOUNG PERSON'S 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 person's safety.

	Y / N	If no, state reason
The child/young person knows about the referral		
The parent/carer knows about the referral		

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.

F. INFORMATION ON STATUTORY STATUS

	Y / N	Please give details of name of child/young person, dates, category (if known)
Any child in family is/has been on the disability register?		
Any child in family is/has been on the child protection register (CPR)?		
Any child or other family member has been looked after by a local authority?		

G. KEY AGENCIES INVOLVED

Insert name of professional if involved	Tel	Insert name of professional if involved	Tel
HV		GP	
Nursery		EWO	
School		Police	
YOT		Dentist	
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.

<p>Child/young person's developmental needs and identified risk factors:</p> <p>Consider health, emotional & behavioural development, education, identity, family & social relationships, social presentation and self care.</p>

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

I. DETAILS OF REFERRER AND SOCIAL WORKER TAKING REFERRAL

Name of worker completing this referral (please print)			
Agency			
Address			
Telephone number			
Signature		Date	

Name of social worker taking referral			
Team		Date	

GUIDANCE NOTES FOR THE INTER AGENCY REFERRAL FORM TO REFER CHILDREN TO SOCIAL SERVICES

This form is to be used by all agencies and individuals when referring a child to Social Services. The information given may be used as part of Social Services initial assessment.

1. The more information received by Social Services at the first point of contact, the more likely it is that appropriate services will be delivered at the earliest opportunity to help children and families in the best interest of the child.

It is not expected that all the boxes on the form will be completed if the information is not available at the time of the referral. Best endeavours must be made to complete it as fully as possible.

Any additional detailed reports should be attached to the form if the consent of the author has been obtained.

2. If the referral is urgent, such as where there are concerns that a child may be suffering significant harm, the referral must be telephoned through to the local Social Services duty team within 24 hours. Within Bexley, these numbers are:

- * West Child Care Unit 020 83037777
- * East Child Care Unit 020 8303 7777
- * Out of Hours team 020 8303 7777
- * Disabled Children's Service 0203 045 3600

This form must be completed and sent or faxed to the local Social Services within 48 hours:

- * West Child Care Unit Fax 0203 045 5445
- * East Child Care Unit Fax 0208 294 6632
- * Disabled Children's Service 01322 351 428

3. The form may be used in Court proceedings.
4. When completing the form it is important to record your observations of the child and the family, both positive and negative.