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|  | **MULTI-AGENCY REFERRAL FORM**FOR ALL CHILDREN, YOUNG PEOPLE AND FAMILY SERVICESReferral Tel: 01753 875362New Email: Send securely to:sloughchildren.referrals@sloughchildrenfirst.co.uk |  Slough Borough Council  |

**Please send electronically in a Word Document**

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| Making a Referral: |
| **Any additional evidence can be attached to the form.**If the reasons for referral include Child Exploitation, Neglect or Young Carers please ensure that the screening tool has been completed and is attached**.**[**Child Exploitation Screening Tool**](https://www.sloughsafeguardingpartnership.org.uk/assets/1/slough_simple_screening_tool_january_2019.docx)[**Neglect Screening Tool**](https://www.sloughsafeguardingpartnership.org.uk/assets/1/slough_neglect_tool_may_21.docx)[**Young Carers**](https://www.sloughfamilyservices.org.uk/kb5/sloughcst/directory/service.page?id=brYFO33_wII)The levels of need set out in the [Slough Safeguarding Partnership Threshold Document](https://www.sloughsafeguardingpartnership.org.uk/assets/1/threshold_document.pdf), should be used by ALL agencies and practitioners to identify needs and risks. |

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| Referrer Details: |
| Completed by: |
| Designation: |
| Organisation: |
| Address: |
| Telephone No: |
| Date: |
| Email: |

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| Consent and Permission: **Seeking consent is the responsibility of the referrer**. |
| Do you have consent to make this referral? Yes [ ]  No [ ] If NO, please provide details here: |
| Do you have permission to share information with agencies? Yes [ ]  No [ ] If NO, please provide details here: |

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| 1. **Child / young person details:**
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| **Full name of child:**  |  |
| **Any alternative name:** |  |
| **DOB:** | **Age**:       Tick if estimated: | **If unborn, estimated date of delivery** |
| **Gender:** | ***Click here to select from list*** |
| **Ethnicity:** |  |
| **Religion:** |  |
| **First language:**  |  | **Will an interpreter be required?** ***Click here to select from list*** |
| **Current Home address:** |       | **Post code:**       |
| **Previous home address: (if known)** |       |
| **Home telephone and Mobile no. of parent / legal guardian:** |  | **Email of parent / legal guardian:**       |
| **School / Pre-school:** |       | **Address& Contact number** :       |
| **Does the child have a disability?**  | ***Click here to select from list*** |
| **If yes give details of the disability:** |       |
| **Unique 13 digit Pupil Number (UPN):**  |       |
| **S.E.N.D or E.H.C.P in place:** | ***Click here to select from list*** | **Date commenced:** |  |
| **NHS Number:** |       |

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| 1. **a) Additional information about the child or young person (including other siblings)**
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| **Parent / legal guardian, children and others living in the household (THIS MUST BE COMPLETED)** |
| Last name | First name | Relationship to child(ren) | DOB / EDD | Gender (M / F) | Ethnicity | Focus of referral Yes/No | School / preschool | Does this person hold Parental responsibility? |
|       |       |       |       |       |       |       |       |       |
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|  **b) Other significant adults**  |
| Last name | First name | Relationship to child(ren) | DOB | Ethnicity | Address | Does this person hold PR |
|       |       |       |       |       |       |       |
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| Professionals involved with the child and family: |
| **Agency** | **Name**  | **Address / email**(full email address) | **Telephone Number** |
| GP |  |  |  |
| School |  |  |  |
| Health visitor |  |  |  |
| CAMHS/MH |  |  |  |
| Other |  |  |  |

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| Reasons for Referral: |
| (please include presenting issues and any historical concerns & complete as fully as possible) |

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| Chronology of Significant Events: |
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| Views of Child / Young Person: |
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| I confirm this is, to the best of my knowledge, a true reflection of the views of the child / young person [ ]  |

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| Views of Parent / Carer: |
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| I confirm this is, to the best of my knowledge, a true reflection of the views of the parent / carer [ ]  |

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| What is your summary? What needs to change and what are your recommendations? |
| **What is going well?** |
| **What are you worried about?** |
| **How have you as an agency helped the child/young person/family?**  |
| **What additional support is required?** |

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| Signed (typed name accepted): | Designation: | Date: |