**INTER-AGENCY REFERRAL FORM**

### This form is to be used by all agencies referring child/children to London Borough of Tower Hamlets CSC for assessment as a child in need, including in need of protection.

### **All urgent referrals should be initiated by phone/fax and with completion of as much of this form as possible or an updated CAF or a Signs of Safety Mapping tool. If information is incomplete, a MASH worker will work through the form to ensure the information is accurate and good quality. If you are a service provider in Tower Hamlets, as part of the Family Wellbeing Model, you may be asked to provide a CAF as well as this form. You should get feedback within 24 hours on this referral and we will proactively work with you and other services to ensure a service is provided to the child, even if it does not meet the thresholds for a statutory response as outlined in the Family Wellbeing Model.**

1. **CHILD/ YOUNG PERSON**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name**  |  | **Forename/s**  |  |
| **DOB/EDD** |  | M |  | F |  | **\*Ethnicity code**  |  | Religion  |  |
| **Child’s first language**  |  | **Is an interpreter or signer required?**  |  |
| **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*

1. **CHILD/YOUNG PERSON’S PRINCIPAL CARERS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FULL NAME**  | **DOB** **If known**  | **Relationship to child**  | **Ethnicity code**  | **Parental** **responsibility**  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **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** **The parent/carer has given consent to the referral.** |  |  |

**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  |
| **H.V.**  |  |  | **G.P.**  |  |  |
| **Nursery**  |  |  | **EWO**  |  |  |
| **School**  |  |  | **Police**  |  |  |
| **YOT**  |  |  | **Dentist**  |  |  |
| **Community mental health**  |  |  | **Community Paediatrician**  |  |  |
| **School Nurse**  |  |  | **Midwife** |  |  |
| **Hospital Consultant** |  |  | **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 (not known). Please record strengths as well as areas of need or risk so that resources can be directed appropriately.

**REASON FOR REFERRAL/REQUEST FOR SERVICES**

|  |
| --- |
| ***What are your concerns? (If an allegation of possible physical abuse, please give specific details of any injury including dates and explanations given)***  |
|  |

|  |
| --- |
| Scale how safe you think the child is:***With 0 being I am certain the abuse will happen again if something is n’t done immediately and 10 being the case needs action but I don’t think the child is in immediate danger, what rating would you give?*****Comments on Score: Please tell us how you reached this score**. |
| ***What existing safety is there for the child(ren) – are there safe people around the child?***  |
| ***What are you most worried will happen to the child(ren) if the situation doesn’t change?*** |
| ***What convinced you to take action now and contact us?***  |
| ***Have you done anything to address this problem (apart from making this referral)? For example has your agency used a CAF or a TAC to focus professional efforts on addressing the concerns? Has the Social Inclusion Panel been consulted for support?***  |
| ***What do you see as the cause of the problem?*** |
| ***What do you expect to happen as a result of this notification?***  |

**I. DETAILS OF REFERRER AND SOCIAL WORKER TAKING REFERRAL**

|  |  |
| --- | --- |
| **Name of worker completing this referral (please print)**  |  |
| **Agency**  |  |
| **Address**  |  |
| **Ward/Consultant**  |  |
| **Telephone number**  |  |
| **Signature**  |  | **Date**  |  |

|  |  |
| --- | --- |
| **Name of social worker taking referral**  |  |
| **Team**  |  | **Date**  |  |
| **Social work context scale (for social worker to complete):*****On a scale of 0 to 10 with 0 being this is the worst case that the agency has ever worked with and 10 indicates that this is a case the agency would take no further action with, where would you rate yourself?***  |