Child Protection Referral To Social Care Services Children & Families Team

Referred to

B&H SW team, West Sussex, East Sussex

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child/Young Person’s name & address (or expectant mother) | | | | | | | | |
| Family Name | | | | | Forenames:  M / F | | | |
| Address: | | | | | NHS No | | | |
| DOB | | | EDD: |
| Telephone Number | | | |
| Postcode | | | | | Child/Young Person’s Religion: | | | |
| Current address if different from above: | | | | | Ethnicity: | | | |
| First Language: | | | |
| Child/Young Person’s principle carers | | | | | | | | |
| Name | | Relationship to child | | | | | Parental Responsibility? | |
|  | |  | | | | | Yes/No | |
|  | |  | | | | | Yes/No | |
|  | |  | | | | | Yes/No | |
| **Other Significant Family and Household members (including siblings and any non-family)** | | | | | | | | |
| Name | DOB | | Relationship to Child | | | Address | | |
|  |  | |  | | |  | | |
|  |  | |  | | |  | | |
| Details of other agencies involved | | | | | | | | |
|  | Name | | | | | Contact details | | |
| GP |  | | | | |  | | |
| MW |  | | | | |  | | |
| HV |  | | | | |  | | |
| SW |  | | | | |  | | |
| School |  | | | | |  | | |
| Other |  | | | | |  | | |
| **Is there an early help/ CAF?** Yes / No | | | | Who is the lead professional? | | | | |
| **Are Parent/s aware of referral? Yes / No Have they given consent for the referral? Yes / No**  **If NO, give reason:** | | | | | | | | |
| **Is this confirmation of a referral previously made by telephone? Yes / No**  If YES, Name of Social Worker who took referral: | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  | | --- | | Reasons for referral and risk assessment of current situation. (include any information on the child’s or unborn baby’s needs, parents ability to meet these needs and any other family/environmental factors which will affect the situation. (see assessment triangle) | | What is working well? Who is involved that helps the child (include other agencies and family, friends and community resources) | | What have you done to help? & What needs to happen? | |  |

|  |  |  |
| --- | --- | --- |
| 1. Details of person completing this referral: please complete in full | | |
| Name: (PRINT)  Designation: | Ward/Department/ Midwifery Team: | |
| Address: | Contact Telephone Number: | |
| Signature: | Date: | |
| 1. **Copy of this referral to:** | | Tick if sent: |
| Patients Records (Mandatory). | |  |
| Debi Fillery Nurse Consultant for Safeguarding children and young people  Level 4, RACH, extension 2363 (mobile 07876 357 456) (Mandatory). | |  |
| Fiona Rose Safeguarding Midwife  Level 4, RACH, extension 2363 (mobile) 07920 503 354 | |  |
| Other (State Title) | |  |