Shared Referral Form

1a. REFERRAL DETAILS

Name of Referrer	Agency	Designation	Postal Address (include postcode)	Email	Phone	Fax
	(Please circle) **Nursery / School** **Health Police** Other (please specify)					

1b. DESIGNATED CONTACT PERSON (If Different From 1a)

Name of Referrer	Agency	Designation	Postal Address (include postcode)	Email	Phone	Fax
	(Please circle) **Nursery / School** **Health Police** Other (please specify)					

2. REFERRAL TO

Date of Referral	Time of Referral (am or pm)	Name of worker spoken to	Designation	Is the parent/carer aware of this referral? Yes/No?		Is the young person aware of this referral? Yes/No?	
Area/Hospital Social Work Team		**Responsible Local Authority**	**Phone**	**Is this a re-referral from your service? Yes/No**		**If yes, please enter date(s) of previous referral(s)**	

3. SUBJECT OF REFERRAL

	Child's Name	Other name known by	DOB dd mm yy	Age	Gender (M/F)	Home Address (include Postcode)	Ethnicity (see list on page 7)	Religion (see list on page 7)
1								
2								
3								

	Preferred Language (see list on page 7)	Interpreter Required (specify)
1		
2		
3		

Child Affected by Disability

Description (see list on page 7)	Communication Assistance Required (specify)

4.FAMILY DETAILS

Mother's Name	DOB (If Known)	Other name known by	Current Address (If different from child)

Father's Name	DOB (if known)	Other name known by	Current Address (if different from child)

4.FAMILY DETAILS (cont'd)

Family Address (include postcode)	Phone (if known)	Is Child Currently Resident at this Address? Yes/No	If No, state Address (include postcode)

Principal Carer's Details (if different from Mother/Father)

Name	DOB (if known)	Relationship to Child	Address (including postcode)	Type of Residence (if not at home)

Other Adults in Household

Name	DOB (if known)	Relationship to Child

Any Other Significant Adult(s) (if known, please include contact details)

Name	DOB (if known)	Address	Phone	Relationship to Child

Siblings not subject to referral

Child's Name	Other name known by	DOB dd mm yy	Age	Gender	If in relation to unborn baby or mother is pregnant – Estimated Date of Birth

5.SUMMARY OF CONCERNS

FOR ALL REFERRALS PLEASE COMPLETE THE FOLLOWING:

Suspicion/risk of (factors relating to the child)	
Absconding	
Child Safety	
Education	
Emotional Care/Development	
Health – Illness/Disability	
Outwith Parental Control	
Physical Care/Neglect	
Self harm	
Sexual Exploitation	
Offender Behaviour	
Substance Misuse	
Other (please specify below)	

Suspicion/risk of (factors relating to parents/ carers)	
Alcohol Abuse	
Asylum Seekers/Refugees	
Domestic Abuse	
Drug Abuse	
Housing/Accommodation	
Learning Disability	
Mental Illness	
Parenting	
Physical Illness	
Poverty/Financial	
Other (please specify below)	

IF APPLICABLE PLEASE COMPLETE:

Suspicion/risk of	
Physical Injury	
Emotional Abuse	
Physical Neglect	
Non-Organic Failure to Thrive	
Sexual Abuse	

6. REASON FOR REFERRAL/REQUEST FOR SERVICES: (please record reason for concern and how this impacts on child. If applicable, please indicate alleged abuser. Indicate what action, if any, you have taken prior to the referral).

7. AGREED ACTIONS (Actions agreed during phone referral)

8. AGENCY INVOLVEMENT

Health	GP's Name	Address	Phone	Email
Health Visitor/School	**Name of Health Visitor/School Nurse**	**Address**	**Phone**	**Email**
Education (Nursery / School)	**Name of School and Contact Person**	**Address**	**Phone**	**Email**
Any Other Agencies (if known)	**Name of Agency and Contact Person**	**Address**	**Phone**	**Email**

Signature of Referrer ______________________ Please print name ______________________

Date ______________________

Signature of Line Manager (if applicable) ______________________ Please print name ______________________

Pick Lists

ETHNICITY	**PREFERRED LANGUAGE**	**RELIGION**	**DISABILITY**
Bangladeshi Black Caribbean Black African Chinese Declined Information Indian Pakistani White Irish White Scottish White Other British Any Mixed Background Any Other Asian Background Any Other Black Background Any Other Ethnic Background Any Other White Background Not Known	Albanian Arabic Bengali Cantonese Eastern European English European Farsi Gaelic Gujarati Hindi Kurdish Sorani Mandarin Mirpuri Persian Punjabi Sign Language Swahili Urdu Unknown Other Language	Agnostic Bahai Buddhist Christian Catholic Christian Protestant Christian Other Declined Information Hindu Jainism Jehovah's Witness Jewish Mormon Muslim Shia Muslim Sunni Non Believer Sikh Taoist Unknown	Autism Hearing Impairment Language/Communication Disorder Learning Difficulties Mental Health Problems No Disabilities but Affected by Disability of Family Member No Disabilities not affected by disability Physical/Motor Impairment Social, Emotional, Behavioural Difficulties Visual Impairment Other Disability (please specify) **TYPE OF RESIDENCE** Children's Unit Foster Placement Friend Pre-Adoptive Placement Residential School Respite Relative Secure Accommodation

Shared Referral Form

Acknowledgement Notification Of Concerns About A Child To Social Work Services

Social Work Services use only (Return to Referrer within 5 working days)

Insert Social Work Services Address

Family Name

SWID No.

Date of Referral

Referral Treated as:

Outcome of Referral/request for Services

Any other comments

Practice Team Leader Signature:

Date