**Children’s Services**

**Multi Agency Referral Form**

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| **Section 1 – Referrer’s Details** | | | |
| This form completed by: | | Role: | |
| Address: | | | |
| Phone No: | Email: | | Date: |

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| **Family Name** | **First Name** | **DoB** | | **Gender** | **Home Address and contact details (tel:)** | | **Nursery/**  **School/College** | **Does the child have a disability? – If yes please specify** |
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| **GP NAME AND ADDRESS:** | | |
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| **Section 3 - Ethnicity** | | | | | | |
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| **White** | **Mixed** | | **Asian** | **Black** | | **Other Ethnic Groups** |
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| **Religion:** | | **Children’s Language:** | | | **Parent’s Language:** | |

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| **Section 4 – Parent/Carers & Other Significant Adults Details** | | | | | | | | | | | | |
| **Parent/Carer** | **Relationship:** |  | | | | | **Parent/Carer** | **Relationship:** |  | | | |
| **Family Name:** |  | | | | | | **Family Name:** |  | | | | |
| **First Name:** |  | | | **Title** | |  | **First Name:** |  | | **Title:** | |  |
| **Gender:** |  | | | **DoB** | |  | **Gender:** |  | | **DoB** | |  |
| **Parental Responsibility:** |  | | |  | | | **Parental Responsibility:** |  | | | | |
| **Address:** |  | | | | | | **Address:** |  | | | | |
| **Postcode:** |  | | **Phone No:** | |  | | **Postcode:** |  | **Phone No:** | |  | |

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| **Other Significant Adult** | | | | | | **Other Significant Adult** | | | | | |
| **Family Name:** |  | | | | | **Family Name:** |  | | | | |
| **First Name:** |  | | **Title:** | |  | **First Name:** |  | | **Title:** | |  |
|  |  | | **DoB:** | |  | **Gender:** |  | | **DoB:** | |  |
| **Relationship:** |  | |  | | | **Relationship:** |  | | | | |
| **Address:** |  | | | | | **Address:** |  | | | | |
| **Postcode:** |  | **Phone No:** | |  | | **Postcode:** |  | **Phone No:** | |  | |
| **Notes to Clarify Care Arrangements:** | | | | | | | | | | | |

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| **Section 5 - Consent** | | | | | |
| **Data Protection Act 1998:** Any information provided will be used within the guidelines outlined in the “Framework for the Assessment of Children in Need and their Families” and “Working Together”. It will be treated in strict confidence and only disclosed as necessary and to any extent appropriate and as required by law or to safeguard a child in the public interest.  Where information is disclosed to other agencies it will be subject to the provisions of the Multi-Agency Disclosure Protocol.  Details may be shared with the family of the child as necessary to safeguard the child and for the assessment process.  **Date family made aware of referral:**  **(The family should be made aware of the referral and the nature of the information being shared. Only in exceptional circumstances of risk should a referral be made without the parents / young person’s knowledge, and the reasons for this should be recorded.)**  **Consent**  To help us make a decision about the right kind of help and support for your family we may need to speak to other agencies. In order to do this we would require your consent. We ask for your permission to exchange relevant information with these professionals.  I/We \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , parent/guardian for the child/ren named in section 2 authorise Wokingham Children’s Services to contact the professionals ticked below to exchange relevant information about our family.  **Parent/Carers Signature:**  **Date:** | | | | | |
| **If “NO”, please record reasons:** | | | | | |
| **Have you already spoken to a Social Worker about this Child / Family?** | | | |  |  |
| **If “YES”:** | **Date:** |  | **Name of Social Worker:** |  | |

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| **Section 6 – Key Agencies Involved (please tick if currently working with family)** | | | | | | |
| **Agency** |  | **Name of worker, email & phone number** |  | **Agency** |  | **Name of worker, email & phone number** |
| **CAMHS** |  |  |  | **Probation** |  |  |
| **Community Mental Health - Children** |  |  |  | **School** |  |  |
| **Community Paediatrician** |  |  |  | **School Nurse** |  |  |
| **Dentist** |  |  |  | **Targeted Youth Services** |  |  |
| **Drugs/Alcohol Services** |  |  |  | **Tier 2/Early Help Services** |  |  |
| **Education Welfare** |  |  |  | **YOS** |  |  |
| **Health Visitor** |  |  |  | **Other** |  |  |
| **Police** |  |  |  |  |  |  |

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| **Section 7 – Reason for Referral:** |
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| **What steps have already been taken to help the family by the referrer/referring agency prior to the making of this referral?** |
| **What is it you are hoping will happen as a result of making this referral today?** |
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| **Section 9 – Voice of the child. (worries/concerns and what they want to happen)** |
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| **Section 10 – Chronology/Timeline** | |
| **Date** | **Brief description of action/event** |
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Please send this form by email to [triage@wokingham.gov.uk](mailto:triage@wokingham.gov.uk)