



Promoting Children & Young People's Well-being

Coventry's Multi Agency Referral & Initial Information Form

Please complete as much information as you can, it will be helpful to the person receiving it. Please put "not known" or "not applicable" as appropriate in any section you are unable to complete. **This form should be used to provide written confirmation of a referral to Social Services at the point of referral or within 48 hours.**
 (Social Services staff **MUST** complete shaded areas)



Key Referral Information					
Time and Date of referral:			Re-referral Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes does the reason for the re-referral indicate that the response to the original referral did not appropriately address the service user's needs. Yes <input type="checkbox"/> No <input type="checkbox"/>					
Name of Person / Professional making referral and relationship to child/young person			Address and contact details:		
			Tel Number:		
Child/Young Person's name and address			SURFACS No		
Surname:		DOB:		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Forename:			Also known as:		
Resides with:		Relationship:		PR/Residence Order:	
Address					
Postcode:			Tel Number:		
Other household members (including non-family members)					
Surname	Forename	DOB	SURFACS No	Relationship to child	Also referred to SSD
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Significant Adults/Parent					
Name		Relationship to child/young person		PR/Residence Order	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the child aware of referral?: Yes <input type="checkbox"/> No <input type="checkbox"/>			Is Parent/Carer aware of referral?: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Child's response to referral:					
Parent / Carers response to referral:					
Child/Young person's religion:			Child/Young person's ethnicity:		
African <input type="checkbox"/> African-Caribbean <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Mixed Heritage <input type="checkbox"/> Other European <input type="checkbox"/> Pakistani <input type="checkbox"/> UK European <input type="checkbox"/> Not Given <input type="checkbox"/>					
Other (please specify):					
Child's first language:			Parent/Carer's first language:		
Is an interpreter required: Yes <input type="checkbox"/> No <input type="checkbox"/>			Other communication needs eg BSL, Makaton etc		
Immigration Status: Asylum seeking <input type="checkbox"/> Refugee status <input type="checkbox"/> Exceptional leave to remain <input type="checkbox"/>					
Nationality			Home Office registration number		

Special Needs or disability: Does the child and/or parents have any special needs, which need to be taken into consideration when responding to this referral?

School or Nursery:

Name

Main Contact

Telephone Number

Key Agencies: (Please give name and contact details of all key professionals involved with family)

	Name	Address	Tel/Fax/E-mail
Health Visitor			
GP			
Paediatrician			
Midwife			
School Nurse			
Nursery / Sure Start			
Education Welfare Officer			
Mental Health			
CAFCASS			
Probation Service			
Voluntary Organisations			
Other			

Child Protection Register Yes <input type="checkbox"/> No <input type="checkbox"/>		Category	
Legal Orders	Date made	To whom	Duration (days)
<p>Details of referral / request for services: Please consider the following headings when making your referral:</p> <p>Child's developmental needs: (Health, education, emotional / behavioural development, identity, family and social relationships, social presentation, selfcare skills).</p> <p>Family and Environmental Factors: (Family history and functioning, wider family, housing, employment, income, family's social integration, community resources).</p> <p>Parenting Capacity: (Basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries, stability)</p>			
<p>What services are already going in / current involvement:</p>			
<p>What services are required? and What is the desired outcome?</p>			
<p>Signature of referrer:</p> <p>Print Name:</p>			
<p>PLEASE FAX COMPLETED FORM TO REFERRAL AND ASSESSMENT TEAM ON FAX NUMBER (024) 7622 5134 - TELEPHONE NUMBER (024) 7678 8555.</p>			

N.B. Form 1A will be used to inform you of the outcome of this referral

Form 1A outcome of referral information / feedback form

Further Action: for completion by Social Worker	
Provision of information / advice <input type="checkbox"/>	Refer to other agencies (please specify) <input type="checkbox"/>
Initial Assessment <input type="checkbox"/> (to be completed within 7 days)	No further Action <input type="checkbox"/>
Reason for further action and details of case allocation:	
Parent informed of action taken	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child / Young Person informed of action taken	Yes <input type="checkbox"/> No <input type="checkbox"/>
Social worker (Print name)	Signature: _____ Date: _____
Endorsed by: (Team manager)	

Feedback on Action taken by Social Services should be given ***within 48 hours*** by returning a copy of this form to the referrer. (If the action taken does not correlate with the expected outcome on the referral telephone contact ***MUST*** be made with the referrer).

Feedback to referrer	
Name of Children	
Home Address	
Form completed by	
Postal Address	
Initial Action taken by Social Services	
<input type="checkbox"/> Commenced Section 47 inquiry/Core Assessment	Date: _____
<input type="checkbox"/> Commenced Child in Need Initial Assessment	Date: _____
<input type="checkbox"/> Redirected to (Please give details)	
<input type="checkbox"/> No Further Action	
Signature of Team Manager	Date: _____
Print Name	