Children's Safeguarding 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.

Child Protection Advice Line Designated number of schools and Children's Centres.	020 7364 5000
Multi-Agency Safeguarding Hub (MASH) To make a referral you need to complete the **interagency form**.	020 7364 5000
Police Child Abuse Investigation Team (CAIT)	020 8217 6484 (or use 999 if not available)
Tower Hamlets Local Authority Designated Officer (LADO) Contact Fiona Anderson for allegations against professionals, staff or volunteers.	020 7364 5000 **LADO@towerhamlets.gov.uk**

Making contact

Email this referral to LADO@towerhamlets.gov.uk

The Telephone number for contact regarding level 4 referrals or to discuss this referral is 020 020 7364 5000

A. 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*

B. 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?***			