**Multi Agency Safeguarding Hub - Referral Form**

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| **Referral Type** | | | | | | | |
|  | **Children’s Social Care** |  | **Children’s Health and Disability Team** |  | **Early Help Service** | | |
| **If threshold is not met for CSC intervention, has consent been given to pass to Early Help Coordinators to explore support for the family?** | | | | | | Yes | No |

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| **Child(ren) in the household** | | | | | | | | | | | | |
| **Forename** | **Surname** | **Date of Birth** | | **Gender** | | **Referring (please tick if yes)** | **Contact number** | | **Ethnicity** | | | **Religion** |
|  |  |  | | Choose an item. | |  |  | | Choose an item. | | | Choose an item. |
|  |  |  | | Choose an item. | |  |  | | Choose an item. | | | Choose an item. |
|  |  |  | | Choose an item. | |  |  | | Choose an item. | | | Choose an item. |
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|  |  |  | | Choose an item. | |  |  | | Choose an item. | | | Choose an item. |
| **Address** |  | | | | | | | | | | | |
| Child(ren)’s first language or preferred means of communication | |  | | Is an interpreter or signer required? | | | Yes | | | | No | |
| Details: | | | | | |
| Nationality | |  | | | | | | | | | | |
| Does the child(ren) have a disability? | | Yes | No | | Details: | | | | | | | |
| Is the child(ren) privately fostered? | | Yes | No | | Is the child(ren) adopted? | | | Yes | | No | | |

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| **Parents/Carers and other significant individuals** | | | | | | | | |
| **Forename** | **Surname** | **Date of Birth** | **Gender** | **Parental Responsibility**  **(please tick if yes)** | **Address**  **(if different from above)** | **Contact Number** | **Ethnicity** | **Religion** |
|  |  |  | Choose an item. |  |  |  | Choose an item. | Choose an item. |
|  |  |  | Choose an item. |  |  |  | Choose an item. | Choose an item. |
|  |  |  | Choose an item. |  |  |  | Choose an item. | Choose an item. |
|  |  |  | Choose an item. |  |  |  | Choose an item. | Choose an item. |
|  |  |  | Choose an item. |  |  |  | Choose an item. | Choose an item. |

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| **Consent** | | | | | |
| If a practitioner believes a child is at risk of significant harm, they have a duty to make a referral. These referrals do not require consent, but it is good practice to inform an adult with parental responsibility that the referral is being made, UNLESS doing so would place the child at risk of significant harm or may lead to the loss of evidence. For all other referrals consent should always be sought from an adult with parental responsibility for the child (or from the child themselves if they are competent) before passing information about them to relevant services. | | | | | |
| How has consent been obtained? | Verbal | Not obtained  Reason: | | Date consent obtained: | |
| Written |
| Have you informed the parent/carer/child about the reason for this referral? | Yes | If yes, what is the parent/carer/child’s view of the referral? | | | |
| No |
| Who has consent been obtained from? | Parent  Name: | | Carer (person with PR)  Name: | | Child  Name: |

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| **Reason for referral** | | | | | | | |
| Please provide as much concise and evidence-based information as possible to help us in our assessment | | | | | | | |
| **Reason for referral *What is the impact on the child(ren)?*** | | | | | | | |
|  | | | | | | | |
| **What is going well for the child(ren)?** | | | | | | | |
|  | | | | | | | |
| **What support is currently in place for the child(ren)?** | | | | | | | |
| Family Early Help Assessment (FEHA)  *Please provide copies of documents* |  | Education Health Care Plan (EHCP) | | |  | My Support Plan (MSP) |  |
| **What needs to change or would help the child(ren)?** | | | | | | | |
|  | | | | | | | |
| **Are there any concerns of going missing from home?** | | Yes | No | Further information can be found at [**www.saferchildrenyork.org.uk**](http://www.saferchildrenyork.org.uk/) | | | |
| **Are there any concerns of exploitation?** | | Yes | No | If Yes, please complete the exploitation screening tool and attach with referral **(available at** [**www.saferchildrenyork.org.uk**](http://www.saferchildrenyork.org.uk/)**)** | | | |
| **Are there any concerns of neglect?** | | Yes | No | If Yes, please complete the neglect screening tool and attach with referral  **(available at** [**www.saferchildrenyork.org.uk**](http://www.saferchildrenyork.org.uk/)**)** | | | |

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| **Currently involved services** | | | | |
| **Role** | **Full name** | **Contact number** | **Email address** | **Address and postcode** |
| Adult Mental Health |  |  |  |  |
| Adult Social Care |  |  |  |  |
| Adult Substance misuse |  |  |  |  |
| Child substance misuse |  |  |  |  |
| CAMHS |  |  |  |  |
| Childcare Setting |  |  |  |  |
| Dentist |  |  |  |  |
| Early Help Service |  |  |  |  |
| Education Provider |  |  |  |  |
| GP |  |  |  |  |
| Housing |  |  |  |  |
| Local Area Coordinator |  |  |  |  |
| Midwife |  |  |  |  |
| Paediatrician |  |  |  |  |
| Youth Justice Service |  |  |  |  |
| 0-19 Healthy Child Service |  |  |  |  |
| 5-19 Health Child Nurse |  |  |  |  |
| **Other, please specify** | | | | |
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| **Referrer’s details** | | | | | |
| **Date of referral** |  | **Time of referral** |  | **Follow up call** | **New referral** |
| **Name of referrer** |  | | **Role** |  | |
| **Agency address** |  | | **Contact number** |  | |
| **Email address** |  | | **Other relevant information to note** |  | |

If referring for Children’s Social Care support please send to [MASH@york.gov.uk](mailto:MASH@york.gov.uk)

If there are concerns about a child or young person at level 4 where the child is considered to be at risk of harm ***make direct contact*** on 01904 551900 or Police (999 in an emergency) and complete this form once the immediate concerns have been addressed.

If the child you are concerned about already has an allocated Social Worker go directly to this person by contacting 01904 551900 and press option 1 – there is no need to use this form.

If referring for Early Help support please send to [earlyhelp@york.gov.uk](mailto:earlyhelp@york.gov.uk)