OXFORDSHIRE

Children's Social Care –Referral Form

OXFORDSHIRE COUNTY COUNCIL
www.oxfordshire.gov.uk

This form should be used to provide written confirmation of referrals within 48 hours. Please complete as much information as you can. **You should have already discussed your referral with the family.**
If, a CAF has been completed already please attach a copy and proceed to page 3 'Reason for Referral'

To	Office:	Fax/Address:	Name: Duty team

Key Referral Information

Date and time of Referral ☐☐ ☐☐ ☐☐☐☐ ☐☐:☐☐

Contact details of referrer

Name of Person / Professional making referral and relationship to child young/person

Name:

Relationship:

Address:

Postcode:

Telephone Number:

Office Number:

Mobile Number:

E-mail Address:

A re-referral is defined as a referral about the same child/ young person within twelve months of a pervious referral to the same council (where the case is closed

Child/Young Person's Details and unborn baby's details

Surname:

Forename:

Also known as:

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

Or EDD (Expected Delivery Date)

☐☐ ☐☐ ☐☐☐☐

Gender:

Male ☐ Female ☐

Address:

Postcode:

Telephone Number:

Please record all names the child and parents/carers have been known by.

This is the child / young person's usual or home address. Where the parents have shared care, the child / young person may have two addresses.

Resides with	**Relationship**	**Parental Responsibility / Residence Order**
1.	1.	1.
2.	2.	2.

TURN OVER

Other household members (including non-family members)

Surname	Forename	Date of Birth	Relationship to child	Also referred to Social Services
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

This section records all children / young people and adults living at the child / young person's usual or home address

If another child / young person in the household is being referred to social services, please tick box

Other significant family members who are not members of the child's household

Name: **Address:** **Postcode:** **Telephone Number:** **Relationship:**	**Name:** **Address:** **Postcode:** **Telephone Number:** **Relationship:**
Parental Responsibility / Residence Order: Yes ☐ No ☐	**Parental Responsibility / Residence Order:** Yes ☐ No ☐

This section records all significant family members who are not members of the child's household.

Referral awareness

Is the child aware of the referral? Yes ☐ No ☐ **Child's response to referral:**	**Is the Parent / Carer aware of the referral?** Yes ☐ No ☐ **Parent / Carer's response to referral:** *Consent can be overridden when there are child protection concerns, but parents should be aware a referral is still being made*

Risk to staff

Is there any information which suggests that there may be a potential risk to <u>workers</u> visiting this child/family?

Yes ☐ No ☐ If yes, specify:

Child / Young Person's Ethnicity

White	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Other Ethnic Groups**
White British ☐	White & Black Caribbean ☐	Indian ☐	Caribbean ☐	Chinese ☐
White Irish ☐	White & Black African ☐	Pakistani ☐	African ☐	Any other ethnic group ☐
Any other White background ☐	White & Asian ☐	Bangladeshi ☐	Any other Black background ☐	Not given ☐
	Any other Mixed background ☐	Any other Asian background ☐		If other, *please specify*

The child / young person or the child's parents should be asked which ethnic group the child belongs to.

This information on ethnicity will enable local authorities to complete statistical returns

Child / Young Person's Religion

None ☐	Christian ☐	Buddhist ☐	Hindu ☐	Jewish ☐
Muslim ☐	Sikh ☐	Any other religion ☐	Not given ☐	

Common Assessment Framework (CAF) / Team Around the Child (TAC)

	CAF		TAC	
Has the child / young person been the subject of a CAF / TAC	Yes ☐	No ☐	Yes ☐	N0 ☐
If yes, please give dates:	☐☐ ☐☐	☐☐☐☐	☐☐ ☐☐	☐☐☐☐

Language and Communication

Child's first language:	**Parent / Carer's first language:**
Is an interpreter required? Yes ☐ No ☐	**Other communication needs (BSL, Makaton etc):**

Special Needs or Disability

Does the child and/or parents/carers have any special needs which need to be taken into consideration when responding to this referral?

Child: Yes ☐ No ☐
If yes, specify:

Parent / Carer: Yes ☐ No ☐
If yes, specify:

On disability register? Yes ☐ No ☐

On disability register? Yes ☐ No ☐

School or Nursery

Name:

Address:

Postcode:

Main Contact:

Telephone Number:

Reason for Referral / Request for Services

Please record brief details about the reason for referral, or services requested by or on behalf of the child.

Pre – Birth referral

Current situation, including any health issues relating to pregnancy / unborn child.

Please record brief details about the reason for referral, or services requested by or on behalf of the child.

Information about family support

Compliance with ante natal care

If unborn child please give some indication of priority (i.e. concerns about other children in families, serious CP concerns regarding parents capacity to care for baby)

Please only make early referrals i.e. before 6 months if there are immediate concerns for other children in the family

Please indicate the priority needs of this referral with timescales

Signature of referrer:	**Print Name:**	**Date:**

Key Agencies

Please give name and contact details of all key professionals involved with the family		Tick if parental consent to contact obtained	Date consent obtained
Health Visitor **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
GP **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Paediatrician **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Midwife **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
School Nurse **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Nursery / SureStart **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Education Social Worker **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Mental Health **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
CAFCASS **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Probation Services **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Voluntary Organisations **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐
Other **Name:**	**Address:** **Tel/Fax/E-mail:**	☐	☐☐ ☐☐ ☐☐☐☐

The name of key professionals from all agencies currently involved with the child and family should be recorded. This includes agencies working with parents.

Parental permission to contact other agencies should be obtained unless permission seeking may itself place a child at increased of significant harm *(Paragraph 5.6, Working Together)*

It should be ascertained whether other professionals agree to the information they are asked to provide being shared with the child and/or family.

Oxfordshire Children's Social Care

Thank you for your referral dated: .....

This concerned: .....

Address: .....
.....
.....
.....
.....

Which we received on: .....

We will let you know the outcome of our assessment. This may be by direct contact or by a copy of our closing letter to the family. Please contact the duty desk if you would like an update on the situation or if you feel there has been a delay in us getting back to you

Thank You