

**Agency referral to Hackney Children’s Social Care**

**Referral form for use by all agencies.**

PLEASE NOTE THAT A WRITTEN REFERRAL FORM IS REQUIRED IN ALL CASES.

WHERE A TELEPHONE REFERRAL HAS BEEN MADE BECAUSE OF THE URGENCY OF A SITUATION THIS MUST BE FOLLOWED UP WITHIN 48 HOURS BY A COMPLETED REFERRAL FORM UNLESS AGREED OTHERWISE.

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| **Name and contact details of person making the referral** | | | | | | |
| **Name:** |  | | | | | |
| **Name of agency/organisation:** | | |  | | | |
| **Address:** |  | | | | | |
| **Telephone Number:** | |  | | | **Fax Number:** |  |
| **Email Address:** | |  | | | | |
| **Date written referral is being made:** | | | |  | | |
| **Date telephone referral made (if applicable) and to whom:** | | | | | |  |
| **Relationship of person making the referral to the child/family:** | | | | | |  |

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| **NAME(S) and DATE(S) OF BIRTH of the child(ren) being referred (please list here all children in the family):** | | | | | | | | |
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| **Child(ren)’s preferred language if not English speaking:** | | | | | |  | | |
| **Ethnic origin and Nationality if known:** | | | |  | | | | |
| **Details of wider social and professional network (e.g. significant family / friends, GP, health visitor, schools, professionals working with members of the household)** | | | | | | | | |
| **Name** | **Role/**  **Relationship** | | **Address** | | | | **Telephone**  **number** | **Email** |
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| **Name of parent(s)/carer(s) with whom child(ren) live(s):** | | | | | | | | |
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| **Parent(s)/Carer(s) preferred language if not English speaking:** | | | | |  | | | |
| **Address:** | | | | | | | | |
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| **Telephone number(s):** | |  | | | | | | |
| **Any other relevant family details:** | | | | | | | | |
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| **Why is a referral being made? What are the concerns? (Please be as specific as possible, giving dates, examples of incidents etc):** | | | |
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| **Is the referral for information only?** |  | | |
| **Is there evidence that any children in the family are being subject to significant harm?** | |  | |
| **If ‘YES’ please specify:** | | | |
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| **Actions taken by referring agency/involvement with the family:** | | | |
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| **Please outline your involvement with the child/family and any ongoing support that is being provided. Detail any past concerns or known involvement of statutory agencies. If a CAF or other assessment document has been completed please attach a copy to this referral.** | | | |
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| **What outcomes are anticipated by the referral?** | | | |
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| **Does the person with parental responsibility know that a referral to Children’s Social Care has been made?** | | |  |
| **If ‘No’ please explain why:** | | | |
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| **If yes, does the person with parental responsibility consent for members of the family’s network to be contacted to obtain further information?** | | |  |
| **Any other information that would be helpful in deciding the priority of the referral and/or understanding the actions Children’s Social Care is being asked to take in respect of the child(ren) being referred?** | | | |
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| Please e-mail this form to [FAST@hackney.gov.uk](mailto:FAST@hackney.gov.uk) for the attention of the Referral Manager. If you need to send it to a **CJSM** email address please send to [fast.account@hackney.cjsm.net](mailto:fast.account@hackney.cjsm.net) .  If you have difficulties sending this by email please fax it to 020 8356 5516/7.  Should you need any assistance in completing this form or wish to follow up your referral please call the First Response Service on **020 8356 5500**.  If your referral has not been acknowledged by Children’s Social Care within three working days please make contact to confirm it has been received.  ***Please ensure that you have sent a copy of this referral to the safeguarding children lead for your agency.*** | | | |