

This form is to assist agencies to either make a referral about a child or young person to children's social care services or confirm a referral in writing already made by telephone (*all professionals making telephone referrals to social services must confirm this in writing within 48 hours*). This form may be posted, transmitted by fax, or sent as an email attachment (see below). The form should be completed, with reference to the Guidance Notes (separately available).

Making a referral/inquiry by telephone
Normal telephone inquiries/referrals: 0845 603 7627
Out of hours (5.30pm - 9.00am Mon - Thurs, 4.30pm Fri - 9.00am Mon and Bank holidays): 0845 606 1212 and Fax 01245 434700
Where there are concerns about the immediate welfare or safety of a child/young person: 0845 603 7634 (all callers) OR 0845 606 1212 (Office hours number for professionals only).

Sending this form to social services
By email to: socialcaredirect@essexcc.gov.uk as an attachment (must be password protected – see guidance notes)
By post to: Essex Social Care Direct, Essex House, 200, The Crescent, Colchester, Essex CO4 9YQ
By fax to: 0845 601 6230

This is a new referral

OR

This is confirmation of a referral I made by telephone on _____ (date), _____ Reference

PART 1 CHILD/YOUNG PERSON'S DETAILS

Family Name:	Given names:			
Date of Birth or expected date of delivery:				
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Unborn <input type="checkbox"/>	
Usual or home address:		Post code:	Tel no.:	
Child or young person's first language or preferred means of communication:				
Is an interpreter required?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Current address if different: (e.g. staying with relative or friend)		Post code:	Tel no.:	
Responsible local authority (if child/young person is known to be in the care of another authority but living in Essex):				
Child/young person's main carers:				
Name	Relationship to child/young person	Ethnicity	First language	Parental Responsibility Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Is an interpreter/signer required?		Mother: Yes <input type="checkbox"/> No <input type="checkbox"/>	Father: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other main carers (please specify name):				
Are any of the main carers disabled?		Mother: Yes <input type="checkbox"/> No <input type="checkbox"/>	Father: Yes <input type="checkbox"/> No <input type="checkbox"/>	

The child/young person or the child's parents should be asked which ethnic group the child belongs to. This information on ethnicity will help us to assess fair access to services by all communities, better plan services and complete statistical returns required by Government (these categories are supplied by Government)

Black or Black British		Asian or Asian British		White		Mixed		Other Ethnic groups	
		Indian	<input type="checkbox"/>			White & Black Caribbean	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	White British	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>	Any other ethnic group	<input type="checkbox"/>
African	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	White Irish	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>	Not given	<input type="checkbox"/>
Any other Black background	<input type="checkbox"/>	Any other Asian background	<input type="checkbox"/>	Any other White background	<input type="checkbox"/>	Any other mixed background	<input type="checkbox"/>	If other, please specify:	

Further details regarding child/young person's ethnicity:
Child/young person's religion:

Child/young person's nationality (if not British and if known):
Nationality: _____ Home Office registration number: _____
Immigration status: Asylum seeking Refugee status Exceptional leave to remain

Child/young person's Unique Pupil Number (if school age and if known): _____
Other Unique identifier (if used – please give identifier and describe what this is): _____

Parent's details if not main carers (and if known):

Mother's name: _____ Mother's address: _____
Postcode: _____ Tel: _____
Mother's first language: _____ Mother's ethnicity: _____
Father's name: _____ Father's address: _____

Does father have parental responsibility? Yes No

Is either parent disabled?
Mother Yes No
Father Yes No

Is an interpreter/signer required?
Mother Yes No
Father Yes No

Agencies involved with the child. Please complete if currently involved with family. You do not need to contact other agencies, social services will do so if necessary.

Agency	Name	Phone No.	If a common assessment has been completed & permission has been given for it to be shared please tick
GP			<input type="checkbox"/>
Health Visitor			<input type="checkbox"/>
Nursery			<input type="checkbox"/>
School			<input type="checkbox"/>
Education Welfare Officer			<input type="checkbox"/>
School Nurse			<input type="checkbox"/>
Community Paediatrician			<input type="checkbox"/>
Dentist			<input type="checkbox"/>
Child and Family Consultation Service			<input type="checkbox"/>
Police			<input type="checkbox"/>
Youth Offending Team			<input type="checkbox"/>
Other			<input type="checkbox"/>

PART 2 REASON FOR REFERRAL

Please give your reasons for referral/request for services (please continue on separate sheet as necessary)

Awareness of referral (The child/young person and parents/carers should be made aware of your intention to make a referral to Social Services, unless there is a specific reason for this being inappropriate, e.g. risk of significant harm)				
Is the parent/carer aware of the referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is child/young person aware?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the parent, carer (or young person if competent) given consent to the referral?	Parent/carer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If No consent please give reason for this being inappropriate
	Young person	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

PART 3: REFERRER'S DETAILS

Referred by			
Agency:		Name:	
Address:			
Post Code	Phone No.	Email address	
Date of any previous referral to Social Services if relevant			
What services are you or your organisation are already providing to the child/young person or family?			
Have you completed a Common Assessment concerning this child/young person? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes please attach)			
Any safety issues to be aware of? Yes <input type="checkbox"/> No <input type="checkbox"/> unknown <input type="checkbox"/>			
If yes please specify			
Completed by:			
NameSignature Date:			

PART 4: TO BE COMPLETED BY ECC STAFF ONLY**Action by Social Care Direct**

Date Received by Social Care Direct

SWIFT Record number:

Date sent to children's operational team:

Action by Children's operational team

Date Received by Children's operational team

Decision by Team Manager on referral: NFA Initial Assessment

Date referral acknowledged

Date outcome of referral notified to referrer (if different)

PART 5: TO BE COMPLETED BY ECC OPERATIONAL TEAM, DETACHED AND SENT TO THE REFERRER

Date:

Referrers Name:

Referrer's Address:

Dear Colleague

Concerning: (Child's/young person's name)

Address: (Child's/young person's address)

Referred on (Referral date)

Thank you for your referral. I am writing to confirm the outcome of your referral.

Decision on referral:

NFA Reason for NFA:

OR

Initial Assessment

Date of decision

Contacts for further inquiries about this referral:

The social worker who should be contacted about this matter is

OR

There is no allocated social worker in this case. Any further inquiries should be directed to (name and contact details)

Signed

Team Manager Name

Team Manager Contact Details