

### Child in Need Information/Referral Form

This form to be used as confirmation of a referral to Social Services and to be submitted within 48 hours of referral. The form may also be used to inform the health visitor/school nurse of child in need concerns where it is considered their service may be appropriate.

CHILD'S NAME			DOB	GP
ETHNIC ORIGIN	FIRST LANGUAGE	GENDER	SCHOOL/NURSERY	RELIGION
COMMUNICATION ISSUES WHERE ASSISTANCE IS REQUIRED				
HOME ADDRESS		ADDRESS OF CARER IF DIFFERENT		
POSTCODE		POSTCODE		
TELEPHONE NUMBER		TELEPHONE NUMBER		
NAME(S) OF THOSE WITH PARENTAL RESPONSIBILITY				
ACCOMPANIED WITH		RELATIONSHIP TO CHILD	DOB	
Parent/Carer aware of referral Yes / No Copy of referral given Yes / No If no, please state reason		Referral sent to: Social services advice and assessment: Yes / No Health visitor / school nurse: Yes / No (Parent/carer to be advise information is being shared)		
PRESENTING PROBLEM				
REASON FOR REFERRAL				
DOES THE CHILD/FAMILY PRESENT ANY RISKS TO STAFF OR OTHER PEOPLE? (e.g. history of violence)				

Please ensure a copy of this form is placed in the child's medical record

Please provide any information you may have on the following

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**CHILD/YOUNG PERSON'S HEALTH/DEVELOPMENT** e.g. any known health concerns, previous presentation at A&E/surgery, is the child's development/growth appropriate to age, attachment to parent/carers, social presentation.

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**COMMENT ON THE ABILITY OF THE PARENTS/CARERS TO ENSURE THAT THE CHILD'S DEVELOPMENTAL NEEDS ARE BEING APPROPRIATELY AND ADEQUATELY RESPONDED TO** e.g. providing basic care, adequately protecting them from harm, providing warmth, stable family environment.

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**FAMILY AND ENVIRONMENTAL FACTORS IMPACTING ON CHILD AND FAMILY** e.g. homeless, known housing problem, parental strengths and difficulties.

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**Summary of concern and action taken**

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**Name of person making referral:**

**Date of referral:**

**Designation of referrer:**

**Department:**

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