**CYSUR – MID & WEST WALES MULTI-AGENCY REFERRAL FORM**

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| **DETAILS OF PERSON MAKING REFERRAL:** | | | | | | | | | | | | |  |
| **Name:** | | | | | **Agency:** | | | | | | **Date:** | |  |
| **Telephone:** | | **Email:** | | | | | | | | **Signature:** | | | |
| **SUBJECT OF REFERRAL:** *(Child, young person or unborn baby)* | | | | | | | | | | | | | |
| **Surname:** | | | **Forename(s):** | | | | | | **Other names used:** | | | | |
| **DOB/EDD:** | **Age:** | | **Gender:** | | | | **Ethnicity:** | | **Preferred Language:** | | | | |
| **Looked After:** Yes / No | | | **CP Register:** Yes / No | | | | | | **NHS Number:** | | | | |
| **Address:** | | | | | | | | | | | | **Post code:** | |
| **Telephone:** | |
| **If allegations of abuse have been made against a professional or a person in contact with children through their work , please specify below:** | | | | | | | | | | | | | |
| **Name & Place of work** | | | | **Date of Birth** | | **Relationship to child** | | **Telephone No.** | | **Any other relevant information** | | | |
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| **REASON FOR REFERRAL / NATURE OF CONCERNS:**  *(including how and why those concerns have arisen, if known)* | | | | | | | | | | | | | |
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| **ADDITIONAL INFORMATION ABOUT THE SUBJECT BEING REFERRED** | | | | | |
| **Has the family resided in another area?** Yes / No / Not known | | **If yes, Why & Where?** | | | |
| **Has the Child / Young Person arrived from overseas?** Yes / No / Not known | | | | | **If yes, Date of Arrival?** |
| **Nationality:** | **Immigration Status:** | | | **Home Office Registration Number:** | |
| **Cultural Needs:** | **Communication Needs:** | | | **Interpreter / Intermediary / Advocate required?** Yes / No / Not known | |
| **Any Disabilities:** | | | **Any Mental Capacity issues:** | | |
| **Any other relevant information:** *(including family history, strengths, vulnerabilities and any other developmental or additional needs)* | | | | | |
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| **VIEWS SHOULD BE SOUGHT WHEREVER POSSIBLE** | |
| **Has consent for referral been obtained from the child?** Yes / No | **Has consent for referral been obtained from the Parent?** Yes / No |
| **Views of the Child / Young Person about making this referral:** | **Views of the Parent(s) about making this referral:**    **Name of Parent(s) giving consent:** |

**Signature of Family Member (with parental responsibility) consenting to referral: …………………………..…………………………………..**

**Name:**       **Date:**

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| **ASSOCIATED PERSONS** | | | | | | |
| **Details of Household members:** *(please include anyone, including siblings, living at the property)* | | | | | | |
| **Names of household members** | **Relationship to child** | **Gender** | **Telephone No.** | **DoB/**  **EDD** | **Ethnicity / Religion** | **Any relevant risk factors** *(including Sub Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)* |
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| **Details of significant persons who are NOT members of the household:** *(please include any family members, including siblings)* | | | | | | |
| **Name & Address of significant person** | **Relationship to child** | **Gender** | **Telephone No.** | **DoB/**  **EDD** | **Ethnicity / Religion** | **Any relevant risk factors** *(including Sub Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)* |
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| **Key Agencies Involved:** *(Consider all areas below and include any key agencies known)* | | | | | | |
| **HEALTH**  (*GP, Health Visitor, Midwife, Community Paediatrician, CMHT, CAMHS, School Health Nurse)* | **EDUCATION**  (*School, FE College, School Nurse, Pupil Support Officer, Welfare/Inclusion Officer, Nursery, School Counsellor)* | | **OTHER STATUTORY SERVICES**  (*Children or Adults’ Social Services, Housing, Probation, Youth Service, Youth Justice/Offending)* | | | **PREVENTATIVE SERVICES**  (*TAF, Child in Need, Youth Service, Sub Misuse Service, Women’s Aid, Support worker)* |
| **Name & Role of Key Person** | | **Address** | | **Telephone No.** | **Email** | |
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