**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** |
|       |       |       |       |       |
| **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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