Bury Integrated Safeguarding Partnership

**Multi-Agency Referral Form**

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| **Date of Referral:** |  |

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| 1. **Details of Referrer** | | | |
| **Name:** |  | **Name of Organisation:** |  |
| **Role:** |  | **Work Address:** |  |
| **Telephone:** |  | **E-mail:** |  |

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| 1. **Details of Children** | | | |
| **Child 1** | | | |
| **Name:** |  | **DOB or EDD:** |  |
| **Address:** |  | **Ethnicity:** |  |
| **School/Nursery:** |  |
| **Gender:** |  | **UPN:** |  |
| **Disability:** | **Y/N** | **NHS No:** |  |
| **Child 2** | | | |
| **Name:** |  | **DOB or EDD:** |  |
| **Address:** |  | **Ethnicity:** |  |
| **School/Nursery:** |  |
| **Gender:** |  | **UPN:** |  |
| **Disability:** | **Y/N** | **NHS No:** |  |
| **Child 3** | | | |
| **Name:** |  | **DOB or EDD:** |  |
| **Address:** |  | **Ethnicity:** |  |
| **School/Nursery:** |  |
| **Gender:** |  | **UPN:** |  |
| **Disability:** | **Y/N** | **NHS No:** |  |
| **Child 4** | | | |
| **Name:** |  | **DOB or EDD:** |  |
| **Address:** |  | **Ethnicity:** |  |
| **School/Nursery:** |  |
| **Gender:** |  | **UPN:** |  |
| **Disability:** | **Y/N** | **NHS No:** |  |

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| 1. **Details of Parents/Carers** | | | | | | |
| **Name 1:** |  | **DOB:** |  | **Tel No:** |  | |
| **Address:** |  | **Relationship to child:** | |  | | |
| **Parental Responsibility:** | | Yes/No | | |
| **1st Language:** |  | **Ethnicity:** |  | **Interpreter req’d:** | | Yes/No |
| **Name 2:** |  | **DOB:** |  | **Tel No:** |  | |
| **Address:** |  | **Relationship to child:** | |  | | |
| **Parental Responsibility:** | | Yes/No | | |
| **1st Language:** |  | **Ethnicity:** |  | **Interpreter req’d:** | | Yes/No |

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| 1. **Details of other significant adults** | | | |
| **Name** | **DOB** | **Relationship** | **Telephone No.** |
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| 1. **Parents’ Consent** | | | | |
| ***There is an expectation that you seek the agreement of the child and family before making a referral to the MASH and explain that multi agency checks will be carried out as part of the referral process.***  ***The expectation is that you have ensured that the parent is in agreement with you making this referral and they consent to multi-agency information sharing within the MASH. Without consent the MASH might not be able to progress the referral UNLESS it is clear that the child is at risk of significant harm/Fabricated or Induced Illness.*** | | | | |
| **Are parents/carers aware of this referral?** | **Yes** |  | **No** |  |
| **Do parents/carers consent to multi agency checks?** | **Yes** |  | **No** |  |
| **If you have answered *YES* please provide details of their responses**. | | | | |
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| **If you have answered *NO* please provide details as to why they have not been informed.** | | | | |
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| 1. **Agencies Involved** | | |
| **Agency** | **Professionals Name** | **Contact Details** |
| **GP** |  |  |
| **Health Visitor** |  |  |
| **School Nurse** |  |  |
| **School** |  |  |
| **Current or previous TAF/TSSF** |  |  |
| **Current or previous Early Help Intervention via locality team** |  |  |
| **Other** |  |  |

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| 1. **Worries** |
| **What have you seen or heard that you are worried about?** |
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| **Voice of the child** |
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| **Voice of the parents** |
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| 1. **Strengths & Safety** |
| **What is going well for this child/family?** |
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| 1. **Education/Health Information** |
| **For Education referrals - please include details of the child/children’s life in school, including attendance.**  **For Health referrals – please include met & unmet health needs.** |
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| 1. **Child with Disability** | | | | |
| **Does this referral require screening by the Childrens Disability Team?** | **Yes** |  | **No** |  |

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| **PLEASE RETURN COMPLETED FORM** |
| The completed multi agency referral form can be sent to the MASH team via email to [childwellbeing@bury.gov.uk](mailto:childwellbeing@bury.gov.uk)  Consultation can be sought from a Duty Social Worker on **0161 253 5678** |