**Multi-Agency Confirmation of Referral to**

**Staffordshire Childrens Advice and Support Service**

This form should always be completed when making a referral to Staffordshire Childrens Advice and Support in the MASH. This is to allow the sharing of information with other agencies. All urgent child protection referrals should initially be made by telephone and then confirmed in writing as soon as possible, **ideally within 24 hours but within a maximum timescale of 48 hours** using this form.

Concerns should be discussed with the child’s parents, making them aware that a referral to Staffordshire Childrens Advice and Support Service has been made, **unless to do so would place the child at risk of significant harm, or any other individual at risk of serious harm, or lead to interference with any potential investigation.** **The child’s safety and well-being must be the overriding consideration in making any such decisions.**

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| **Referrer Details** |
| Referred by: |  |
| Designation: |  | Agency: |  |
| Referrer’s Address: |  | Post Code: |  |
| Tel. no |  | Mobile no. |  |
| E-mail |  |
| Date of Referral: |  | Time: |  |
| Name of person receiving the referral: |  |
| Is the parent/carer aware of the referral? Please tick appropriate box | Yes |  | No |  |
| Is child/young person aware of referral? Please tick appropriate box  | Yes |  | No |  |
| **Child/Young Person’s Details** |
| Name of the child / young person: |  | Known As / Aliases: |  |
| DOB *(or expected date of delivery):* |  | Gender | Male  |  |
| Female  |  |
| Unborn  |  |
| Home Address *(Inc. postcode):* |   |
| Tel No *(including mobile numbers)*: |  |
| Any other known addresses *(Inc. postcode):*  |  |
| Child / young person’s ethnicity:  |  |
| Child / young person’s first language: |  |
| Child / young person’s religion |  |
| Parent / carer’s first language: |  |
| Does the child / young person have a disability? |  |
| Is an interpreter / signer required? |  |
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| **Additional Information:** |
| Is the child / or has the child / young person been the subject of a child protection plan? **Y/N** |  |
| If yes, please state in which local authority and provide further details if known: |
| Is the child or has the child / young person been a looked after child? **Y/N** |  |
| **If yes, please state in which local authority and provide further details if known:** |
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| **Reason for Referral*****(Please include as much information as possible. Remember that the assessment of the level of intervention required will be based upon the information that you provide. You will need to consider the child’s developmental needs; parenting and / or carer capacity to meet the child’s needs; and family and environmental factors****).* |
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| **Known risks within this household?** (*E.g. violent/aggressive individuals, drug use/dealing, weapons etc.)* |
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| **Details of Child/Young Person’s Principal Carers** |
| Name | D.O.B | Relationship to child/young person | Parental Responsibility (PR)? **Y/N** |
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| **Other people living in the child / young person’s household** |
| Name *(including any known aliases)* | D.O.B | M / F | Relationship to child / young person |  Also Referred? **Y / N** |
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| **Significant others who are not members of child / young person’s household** |
| Name  | P.R?**Y/N** | D.O.B | M / F | Relationship to child / young person | Current Address | Tel. No. |
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| **Key Agencies** *(please provide the information below)* |
| Agency | Name | Tel. No./Contact details |
| G.P |  |  |
| Midwife |  |  |
| Health Visitor |  |  |
| School Nurse |  |  |
| Children’s Centre |  |  |
| Nursery |  |  |
| School |  |  |
| School Nurse |  |  |
| Education Welfare Officer |  |  |
| Youth Offending Service |  |  |
| Police |  |  |
| Probation Service |  |  |
| Paediatrician |  |  |
| CAMHS |  |  |
| Other *(please state)* |  |  |

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| **Early Help Assessments (EHA) Details** |
| Has a EH assessment been completed?  | **Yes** *(please attach to referral)* | **No** | Date EH assessment completed |  |
|  |  | EHA unique ref. number(s) |  |
| Name of Lead Worker |  | Agency |  |
| Address |  | Contact details (Tel. no./ e-mail) |  |
| Has consent for a EH assessment ever been refused?  | **Yes** | *If yes please state the date of when it was refused* | **No** |
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| **Authorisation** |
| Have you discussed this referral with your line manager? **Y/N** |  |
| **Details of Manager/Supervisor:** |
| Name: |  | Designation: |  |
| Tel no. |  | E-mail |  |
| Referrer’s Signature: |  | Date: |  |
|  |  |  |  |
| **Once you have completed this form please send it to:** |
| **STAFFORDSHIRE REFERRALS:** |
| **Staffordshire County Council's Childrens Advice and Support Service: 0300 111 8007** (Monday-Thursday 8:30am - 5:00pm and Friday 08:30am - 4:30pm)If you have already made your enquiry by telephone please submit this MARF using the following link:<https://www.staffordshire.gov.uk/Care-for-children-and-families/childprotection/First-Response.aspx>**Emergency Duty Service** (Outside office hours): 0345 604 2886 |
| **\***Please note that any information sharing needs to be in accordance with your agency’s information governance processes. If you are unsure, please check with your agency’sdesignated safeguarding lead. |