

Multi-Agency Safeguarding Children's Referral Form for Liverpool Children's Services

How to complete this referral form

The purpose of this form is to ensure that, when you refer to Children's Services, you provide as much information as possible to enable us to deal with your referral quickly. It is not expected that you will have all the information specified. Sections you are unable to complete please draw a line through.

| Name of Referrer | | Date of referral | | |
|-------------------------|--------------------------------|------------------------|-----------|-----------------|
| | | | | |
| Designation/ Title | | | | |
| Address | | | | |
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| | | | | |
| Postcode | Phone | | Fax | |
| | | | | |
| Email Address | | | | |
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| DO YOU CONSIDER 1 | HE CHILD/ YOUNG PERSO | N TO BE AT RISK C | F SIGN | IIFICANT HARM? |
| Yes | No | | | |
| | | | | |
| If YES, please make ar | immediate telephone referr | al to Careline Childre | n's Ser | vices: 0151 233 |
| 3700 (24 hours/ 7 days | a week) | | | |
| In an emergency, conta | ct the Police on 999 | | | |
| in an emergency, come | of the Folice of 555. | | | |
| All telephone referrals | nust be followed up in writing | g within 48 hours by a | a written | referral |
| | | | | |

Referrer Details

| Details of the child | (ren) being referred – Please i | nclude siblin | gs | |
|----------------------|---------------------------------|---------------|--------|-----------|
| First Name | Surname (including any aliases) | DOB / Age | Gender | Ethnicity |
| | | | | |
| | | | | |

| Address | | Tolo | phone No | |
|-------------------------|--|-----------------|------------------|-------------|
| Address | | reie | sprione ivo | |
| | | | | |
| Postcode | | | | |
| Child/ Young Persor | n's Principal Carers – ple | ase include pa | rtners / signifi | cant others |
| Full Name | DOB | Ethnicity | Relationshi | p to child |
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| subject, and provide | lity – Can you indicate we us with an address and responsibility shared? | contact numbe | | |
| Name: | - Ada | Iress and Numb | or | |
| Name. | Auc | iress and Numb | iei | |
| | | | | |
| | | | | |
| Is the above person | the main carer? Yes □ | No 🗆 | | |
| Is an interpreter/ sig | ner required? Yes | | No 🗆 | |
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| Give full details of la | inguage/ requirements: | | | |
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| Is the child/ young p | erson or any family mem | ber affected by | y a disability? | |
| Yes | No | | | |
| | | | | |

| If yes, please give details | |
|-----------------------------|--|
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| DETAILS OFKEY | PROFESSIONA | LS/ AGENCIE | ES INVOLVED |
|----------------------------|-------------------------------------|-------------|-------------|
| | Name of Professional Involved | Tel No | Address |
| GP | | | |
| Health Visitor | | | |
| Midwife | | | |
| School | | | |
| Nursery | | | |
| YOT | | | |
| Mental Health Services | | | |
| School Nurse | | | |
| EWO | | | |
| Connexions | | | |
| Community Paediatrician | | | |
| Police | | | |

| state) | | | | | |
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| Reason for Referr possible) | ral – Clearly state | the cause (s) f | for concern (please | try and be specific as | |
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Other (please

| Has the referrer received consent from the family to make this referral to Children's |
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| Services? |
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| |
| Yes No |
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| (It is important that the parents are aware of and agree with this referral, unless |
| (It is important that the parents are aware of and agree with this referral, unless |
| this would place the child at risk of harm. Please remember that you can still refer your concerns, if |
| the parents are not giving their consent)) |
| |
| If the family are not aware of the referral, please state why. |
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| ASSESSMENT FACTORS | |
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| 1. DEVELOPMENT OF BABY, CHILD OR YOUNG | |
| | |
| a) Health and Physical Development - Medical conditions or impairments, development | opment checks, |
| access to dentists/ GP services, immunisations, accidents and hospital admissions | |
| | |
| | Mark box if |
| unknown □ | |
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| b) Frankland and Oakla De | man maladi l · |
| b) Emotional and Social Development - attachments, confidence, ability to for | orm relationships, |

| dealing with stress, anxieties, any psychological issues. | |
|--|--------------|
| unknown 🗆 | Mark box if |
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| c) Behavioural Development - lifestyle, maturity, anti-social behaviour, violenc misuse. | e, substance |
| unknown 🗆 | Mark box if |
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| d) Identity, including self-esteem, self image and social presentation - perception of self, confidence, personal/ family history, experiences of discrimination. Mark box if unknown e) Family and Social Relationships - relationships with family and friends, and wider community. | | |
|--|---|---------------------------|
| confidence, personal/ family history, experiences of discrimination. Mark box if unknown | | |
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| unknown □ | | |
| unknown | confidence, personal family history, experiences of discrimination. | |
| unknown | | |
| unknown | | Mark hox if |
| | _ | Mark box II |
| e) Family and Social Relationships - relationships with family and friends, and wider community. | unknown 🗆 | |
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| | e) ramily and Social Relationships - relationships with family and frie | nas, and wider community. |

| Ability to maintain positive relationships. | |
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| unknown 🗆 | Mark box if |
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| 2. PARENTS AND CARERS | |
| a) Basic care, ensuring safety and protection – provision of basic care, i.e. for shelter, clothing. Not exposing child to risk; lack of supervision, witnessing violence | od, water, warmth, |
| unknown □ | Mark box if |
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| b) Emotional Warmth and stability | - ability to display affection and warmth, secure attachments, |
|-----------------------------------|--|
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| appropriateness of responses. | |
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| | Mark box if |
| unknown □ | Mark box if |
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| c) Guidance, boundaries and stimulation | | |
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| Encouraging positive behaviour, appropriate guidance and use of discipline. | | |
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| | Mark box if | |
| unknown □ | | |
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| 3. Family and Environmental | | |
| a) Family bistoms functioning and a little in family | ant/illness bist | |
| a) Family history, functioning and well-being – family bereavem | nent/ lilness, history of | |
| relationships, family dynamics, breakdown of relationships, presence of violence, aggression, substance misuse, mental health issues or disabilities. | | |
| , | Mark box if | |
| unknown □ | | |
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| b) Wider family – evidence of support networks. | |
|--|-------------|
| b) Wider family – evidence of support networks. | |
| | Mark box if |
| b) Wider family – evidence of support networks. unknown | Mark box if |
| | Mark box if |

| c) Housing, employment and financial considerations – temporary/ poor quality | |
|--|----------------|
| homelessness, threat of eviction, over-crowding, debt, poor budgeting, unemployr | nent. |
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| | Mark box if |
| len a | Mark box II |
| unknown □ | |
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| d) Social and community elements – availability of resources – nursery provision | n/ playgroups, |
| leisure activities | |
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| | Mark box if |
| unknown – | NVA II |
| unknown □ | |
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| ANY OTHER COMMENTS | |
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| ANY OTHER COMMENTS: | |
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| Signed | Date | | | |
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| Please Print Name | I | | | |
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| | | | | |
| Please send this form to Careline Children's | Services via our postal address: - | | | |
| Careline Children's Services | | | | |
| Liverpool City Council | | | | |
| Municipal Buildings | | | | |
| Dale Street | | | | |
| Liverpool | | | | |
| L2 2DH | | | | |
| Or by our Fax number: 0151 225 2275 | | | | |
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| Date Referral Received in Careline | | | | |
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| A copy of this form is also available on Careline's Internet page by visiting: - | | | | |
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 $http://www.liverpool.gov.uk/Health_and_social_care/Social_services/Careline/index. as$

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