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**Emergency Duty Team (EDT)**

**(Evenings & Weekends)**

**Tel: 020 8708 5897**

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#  LB REDBRIDGE MULTI - AGENCY REFERRAL FORM (MARF)

This form is to be used by all agencies referring a child/young person to LB Redbridge Children’s Social Care for assessment as a child in need, in need of protection and/or children and young people **that are being** [**privately fostered**](http://www.redbridgelscb.org.uk/professionals/private-fostering/)**.**

**All urgent referrals should be initiated by phone and followed up in writing within 24 hours, by completion of as much of this form as possible. Please PRINT clearly.**

1. **CHILD/YOUNG PERSON**

|  |
| --- |
| **Child/Young Person’s Ethnicity:** |
| The categories below are defined by the Department of Health and Social Care (DHSC). In addition to helping us to consider the particular needs of the child/young person being referred, this information, when will allow better planning of the services. |
| Caribbean [ ]  | Indian [ ]  | White British [ ]  | White and Black Caribbean [ ]  | Chinese [ ]  |
| African [ ]  | Pakistani [ ]  | White Irish [ ]  | White and Black African [ ]  | Bangladeshi [ ]  |
| Any other Black background [ ]  | Any other White background [ ]  | Any other Asian background [ ]  | Any other Mixed background [ ]  | Not given [ ]  |
| Any Other (please specify) [ ]  |  |

|  |  |
| --- | --- |
| **Religion:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name** |  | **Forenames** |  |
| **D.O.B** |  / / | **Gender** | **Unborn** | Y / N | **Expected D.O.B** |  / / |
| M □F □  |
| **Child’s First Language** |  | **Is an Interpreter or Signer Required?** |  Y / N |
| **Responsible** **Local Authority** |  | **Child/Young Person** **known to be in care of** **another Local Authority** | Y / N |
| **Address** |  |
| **Postcode** |  | **Tel.** |  |
| **Current address if different from above** |  |
| **Postcode** |  | **Tel.** |  |

1. **CHILD/YOUNG PERSON’S PRINCIPAL CARERS.**

**(Please consider if the child/young person is being privately fostered)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FULL NAME** | **DOB** | **RELATIONSHIP TO CHILD** | **ETHNICITY** | **PARENTAL RESPONSIBILITY** |
|  |  |  |  | Y / N |
|  |  |  |  | Y / N |
|  |  |  |  | Y / N |
| **First Language of Carers:** |  | **Is an interpreter or signer required:**  | Y / N |

**C. OTHER HOUSEHOLDMEMBERS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FULL NAME** | **DOB** | **RELATIONSHIP TO CHILD/YOUNG PERSON** | **ETHNICITY**  | **TICK IF ALSO REFERRED** |
|  |  |  |  |  |
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**D. OTHER SIGNIFICANT PEOPLE IN THE CHILD/YOUNG PERSONS LIFE, INCLUDING OTHER FAMILY MEMBERS.**

|  |  |  |  |
| --- | --- | --- | --- |
| **FULL NAME** | **RELATIONSHIP TO CHILD/YOUNG PERSON** | **ADDRESS** | **TEL. NO.** |
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| **REFERRALS WILL BE SHARED WITH THE FAMILY AND SHOULD NOT BE MADE WITHOUT THEIR KNOWLEDGE/AGREEMENT UNLESS THIS WOULD JEOPARDISE THE CHILD/YOUNG PERSONS SAFETY.** |
|  |  **Yes/No** | **If No - State Reason** |
| **The child/young person knows about the referral.** |  |  |
| **The parent carer knows about the referral.** |  |  |

**E. REASON FOR REFERRAL/REQUEST FOR SERVICES**

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| **If an allegation of possible physical abuse, please give specific details of any injury including dates and explanation given.** |
|  |

**F. INFORMATION ON STATUTORY STATUS**

|  |  |  |
| --- | --- | --- |
|  | **Y/N** | **Please give details of name of child/young persons, dates, category (if known).** |
| **Any child in family is/has been subject to a child protection plan?** |  |  |
| **Any child or other family member is/has been looked after by a local authority?** |  |  |
| **Any child in the family had/has a statement of educational needs (SEN)?** |  |  |
| **Any child in the family is/has been on the disability register?** |  |  |

**G. KEY AGENCIES INVOLVED**

|  |  |  |  |
| --- | --- | --- | --- |
| **Insert name of professional if involved.** | **Tel.** | **Insert name of professional if involved.** | **Tel.** |
| **H.V** |  |  | **G.P** |  |  |
| **Nursery** |  |  | **EWO** |  |  |
| **School** |  |  | **Police** |  |  |
| **YOT** |  |  | **Midwife** |  |  |
| **Community Mental Health** |  |  | **Community Paediatrician** |  |  |
| **School Nurse** |  |  | **Other** |  |  |

**H. INFORMATION SUPPORTING THIS REFERRAL**

The purpose of this section is to assist the inter-agency assessment. Where you have no information about a particular area, please write ‘Not Known’ (N/K). Record strengths as well as areas of need or risk so that resources can be directed appropriately.

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| **Child/Young person’s development needs and identified risk factors:*****Consider health, emotional and behavioural development, education, identity, family and social relationships, social presentation and self care.*** |
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| --- |
| **Risk Indicators:** |
| Drug and/or alcohol misuse [ ]  | Mental Health Issues [ ]  | Domestic Violence [ ]  |
| Other…………………………… |  |  |

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| --- |
| **Parents/Carers capacities to respond to child/young person.*****Consider basic care, ensuring safety, emotional warmth, stimulation, provision of guidance and boundaries, and stability.*** |
|  |
| **Issues affecting parent/carers capacity to respond appropriately to child/young person’s needs.** |
|  |
| **Family and environmental factors which impact on the child.*****Consider family history and functioning, the wider family, housing, employment, income, the family’s social integration and the availability of community resources to provide support.*** |
|  |
| **Risks/Hazards** ***Please record any issues which may present a risk to others i.e. violence, aggressive dogs etc.*** |
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| --- | --- |
| **Name of worker completing referral** |  |
| **Position/Title** |  |
| **Agency** |  |
| **Address** |  |
| **Tel** |  |
| **E-mail** |  @ |
| **Signature** |  | **Date** |  / / |
| **Signature of manager*****\*if applicable*** |  | **Date** |  / / |

|  |  |
| --- | --- |
| **Name of social worker taking referral** |  |
| **Team** |  | **Date** |   / / |

**NB:** Please e-mail to CPAT.Referrals@redbridge.gov.uk