

# COUNCIL OF THE ISLES OF SCILLY

## CHILDREN IN NEED

### INTER-AGENCY REFERRAL GUIDANCE

#### NOTES

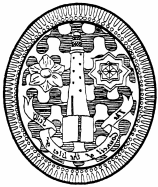
Improving Services for  
Children in Need

1. Please complete the form as fully as possible. Some sections may not apply to you e.g. if you are outside the Education system, you will not be expected to complete the section on Code of Practice. It is very important that full details of names, dates of birth, addresses and ethnicity are completed. Please indicate who has parental responsibility under the Children Act 1989.
2. To avoid delay if we need to contact you, please be specific about your contact details, especially if you work part-time or work from different locations at different times.
3. Wherever possible, the permission of parents/carers/children/young people (as appropriate to age and understanding) should have been sought before contacting Isles of Scilly Council Children's Social Care Services and before Children's Social Care Team discuss the referral with any other agency. However, "this should only be done where such **discussion and agreement seeking will not place a child at further risk of significant harm or prejudice enquiries under Section 47 of the Children Act 1989, or a police investigation**". Where possible you may wish to fill in the form whilst with the family and obtain their signatures before sending to Children's Social Care Services.

**If parental permission is refused and you consider the child to be at risk of significant harm, the interests of the child must come first and therefore the referral must go ahead.** Please ensure that you document the reasons for your actions. If you are making the referral without the knowledge of the family, Children's Social Care will need to discuss the situation with you before taking any further action.

4. By completing this referral form as comprehensively as possible, you will be helping Children's Social Care to make their decision on further action within the time scales set by the Framework for the Assessment of Children in Need (2000). You will also help determine the child's priority level with the Children's Social Care eligibility criteria. In particular, details of any work you have already done with the family, when you last saw them, and the child or young person, and specific information about what might need to change to help the child's development are essential.
5. If you are making a referral because of child protection concerns, you will need to telephone Children's Social Care, following up with this referral form, as soon as possible, but within 24 hours.
6. On receipt of your referral, Children's Social Care will complete Part B, returning a copy to you. Please note that wherever possible Children's Social Care will use this referral as a significant part of their initial assessment and therefore they may contact you to clarify the information you have provided.
7. If you have any difficulties or queries, please do not hesitate to contact your Child Protection Supervisor or the Children's Social Care Team.

Children's Social Care Services  
Carn Thomas Children's Centre  
St. Mary's  
Isles of Scilly  
TR21 0PT



# CHILDREN IN NEED INTER-AGENCY REFERRAL

Please ✓ all appropriate boxes  
Please complete legibly in BLACK INK

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## Child/Young Person's Details

Agency Ref. No.: \_\_\_\_\_

Surname: \_\_\_\_\_

AKA: \_\_\_\_\_

Forename(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: Male

Female

Unborn

Current Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Type of Address: \_\_\_\_\_

Tel No. (inc. code): \_\_\_\_\_

Home Address (if different): \_\_\_\_\_

Postcode: \_\_\_\_\_

Tel No. (inc. code): \_\_\_\_\_

Child/young person's ethnicity:

A1 White – British

B4 Mixed - Any other mixed background

D1 Black or Black British - Caribbean

A2 White – Irish

C1 Asian or Asian British – Indian

D2 Black or Black British – African

A3 White – Any other White Cultural Background

C2 Asian or Asian British – Pakistani

D3 Black or Black British - Any other Black background

B1 Mixed - White and Black Caribbean

C3 Asian or Asian British – Bangladeshi

E1 Chinese

B2 Mixed -White and Black African

C4 Asian or Asian British – Any other Asian background

E2 Any other ethnic group

B3 Mixed - White and Asian

If E2, Nationality: \_\_\_\_\_

Religion: \_\_\_\_\_

Child's first language: \_\_\_\_\_

Parent/carers' first language: \_\_\_\_\_

Interpreter/signer required? Yes

No

If Yes, give details: \_\_\_\_\_

Does child/young person have a disability? Yes

No

If Yes, give details: \_\_\_\_\_

Other special/cultural needs: \_\_\_\_\_

Has child/young person received a statement of Special Educational Needs? Yes

No

On Code of Practice? Yes

No

Child/young person's GP (if known): \_\_\_\_\_

School attended: \_\_\_\_\_

Is this a referral for action under Child Protection Procedures? Yes

No

If Yes, please give details: \_\_\_\_\_

Legal Status of child: \_\_\_\_\_

**Details of Referrer**

Surname:  Forename(s):

Post:

Agency & Address:

Postcode:

Tel No. (inc. code):

When can referrer be contacted?

Is parent aware of referral? Yes  No

Is child/young person aware of referral? Yes  No

**Parents/Persons caring for child/young person:**  if parental responsibility

Surname	Forenames	M/F	AKA	Address/Tel No.	Date of Birth	Relationship to child
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Other children in household (please indicate by \* against name if another child/young person is also being referred):**

Surname	Forenames	M/F	AKA	Date of Birth	Relationship to child
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Significant others/other family members**  if parental responsibility

Surname	Forenames	M/F	AKA	Address/Tel No.	Date of Birth	Relationship to child
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Agencies/professionals known to be involved**

Name:

Agency:  Tel No. (inc. code):

Name:

Agency:  Tel No. (inc. code):

Name:

Agency:  Tel No. (inc. code):

Name:

Agency:  Tel No. (inc. code):

Name:

Agency:  Tel No. (inc. code):

Has consent been given for Children's Social Care Services to contact the named agencies? Yes  No

If No, please specify with reasons:

**Specific reasons for referral (include strengths and difficulties or any specific incidents of concern):**

**Child/young person's development needs (consider health, education, identity, social presentation, emotional and behavioural development, self-care skills, family and social relationships):**

**Parenting capacity (consider relevant issues in relation to basic care, ensuring safety, emotional warmth, stimulation boundaries, stability in relation to the child/young person's developmental needs):**

**Are there any issues which affect parent(s) capacity to respond appropriately to child/young person (e.g. physical/mental illness or disability; learning disability; substance/alcohol misuse; domestic violence, childhood abuse):**

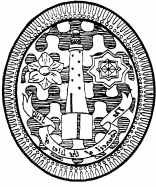
**Family and environmental factors (relevant information about family history, social integration & functioning; support in wider family/community; housing, employment, income & financial difficulties):**

**What action has referrer already taken?**

**What does referrer expect to happen next (be specific about focus for any assessment)?**

**NOTE: Information provided on this form will be shared with families and young people, if relevant to assessment and planning, unless indicated otherwise by the referrer or where sharing would put any individual at risk of harm.**

Signature of referrer:	<input type="text"/>	Date:	<input type="text"/>
Signature of parent/carer:	<input type="text"/>	Date:	<input type="text"/>
Signature of child/young person: (where relevant)	<input type="text"/>	Date:	<input type="text"/>



# CHILDREN IN NEED INTER-AGENCY REFERRAL – INITIAL DECISION

Please ✓ all appropriate boxes  
Please complete legibly in BLACK INK

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Children in Need

## Part A – To be completed by the Referrer

Referrer's Name:

Referrer's Address:

Postcode:

Name(s) of child/young person referred	Date(s) of Birth

## Part B – To be completed by Children's Social Care Services or Receiving Agency

Following the referral dated  in respect of the child(ren)/young person(s) named above. I write to advise you that this is the outcome:

Please see note below, or attached:    initial assessment     summary of initial assessment

Name:

Post Title:

Address:

Postcode:     Tel No. (inc. code):

Signed:     Date:

Manager Comments:

Manager Signature:     Date:

NFA:  Reason:

Pending:  Priority:

Allocated:  Worker:  Caseload Category:

Referrer Contacted: Yes

Date:

Telephone  Letter