

**CHILDREN'S SERVICES SINGLE REFERRAL FORM**

"The best for every child, young person and family..."



**INFORMATION**

Professionals wishing to refer a child, to Cumbria Children's Services for assessment should complete this form. Once completed the form should be sent to the priority service you are seeking help from. Addresses for these services can be found in the Children's Services Case Management Service Directory, available online from:

**<http://www.cumbriacc.gov.uk/childrenservices/casemanagement>**

The form is intended to reduce the need for multiple referrals for families and to ensure that Cumbria Children's Services has the fullest available information when making decisions about the appropriate response to any referral. The form should be completed as fully as your knowledge or information allows. Please mark any sections you are unable to complete as "not known". A completed Common Assessment may be used to replace parts of the form marked with a double asterisk (\*\*).

**IF THE CONCERNS ARE OF AN URGENT NATURE (i.e. a child appears to be suffering or likely to suffer significant harm) Children's Services Social Care must be contacted immediately by telephone, with this form completed and sent within 48 hours.**

**IF THIS FORM IS CONFIRMATION OF AN URGENT REFERRAL MADE BY TELEPHONE, PLEASE STATE THE NAME OF THE PERSON WHO TOOK THE REFERRAL AND THE DATE IT WAS MADE:**

**FULL NAME:**  **DATE:**

**Has a CAF Pre-assessment Checklist been completed?**

**If Yes – please continue with this form  
If No – please complete now, before continuing with this form, available from web site as above.**

**CHILD/YOUNG PERSONS DETAILS**

Please Specify:  Surname:   
Mr/Master/Mrs/Miss/Other

First Name(s):

AKA/Previous Names:

Male  Female  Unknown  Date of Birth or EDD<sup>1</sup>

Address:

Contact Tel:  Unique Pupil No:

Child/Young Persons first language or preferred means of communication

**Interpreter/Signer Required**  **YES / NO** (Please delete as appropriate)

<sup>1</sup> EDD – Expected Delivery Date

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**REFERRER'S DETAILS**

Please Specify:  
Mr/Mrs/Miss/Other

Surname:

First Name(s):

Agency/Relationship to child if non-professional:

Office Address:

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Telephone Number:

Mobile No:

**Has the referrer informed Parent/Carer of this referral?**

(Please see Information Sharing section – Page 8)

**YES / NO**

(Please delete as appropriate)

If Yes – please provide name/relationship of Parent/Carer informed:

→

If No – please give reason:

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**Has the Child/Young Person been informed of this referral?**

**YES / NO**

(Please delete as appropriate)

If 'Yes' please provide - name of Child/Young Person informed – if more than one:

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If 'No' please state reason:

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**QUESTIONS/ACTIONS REQUIRED**

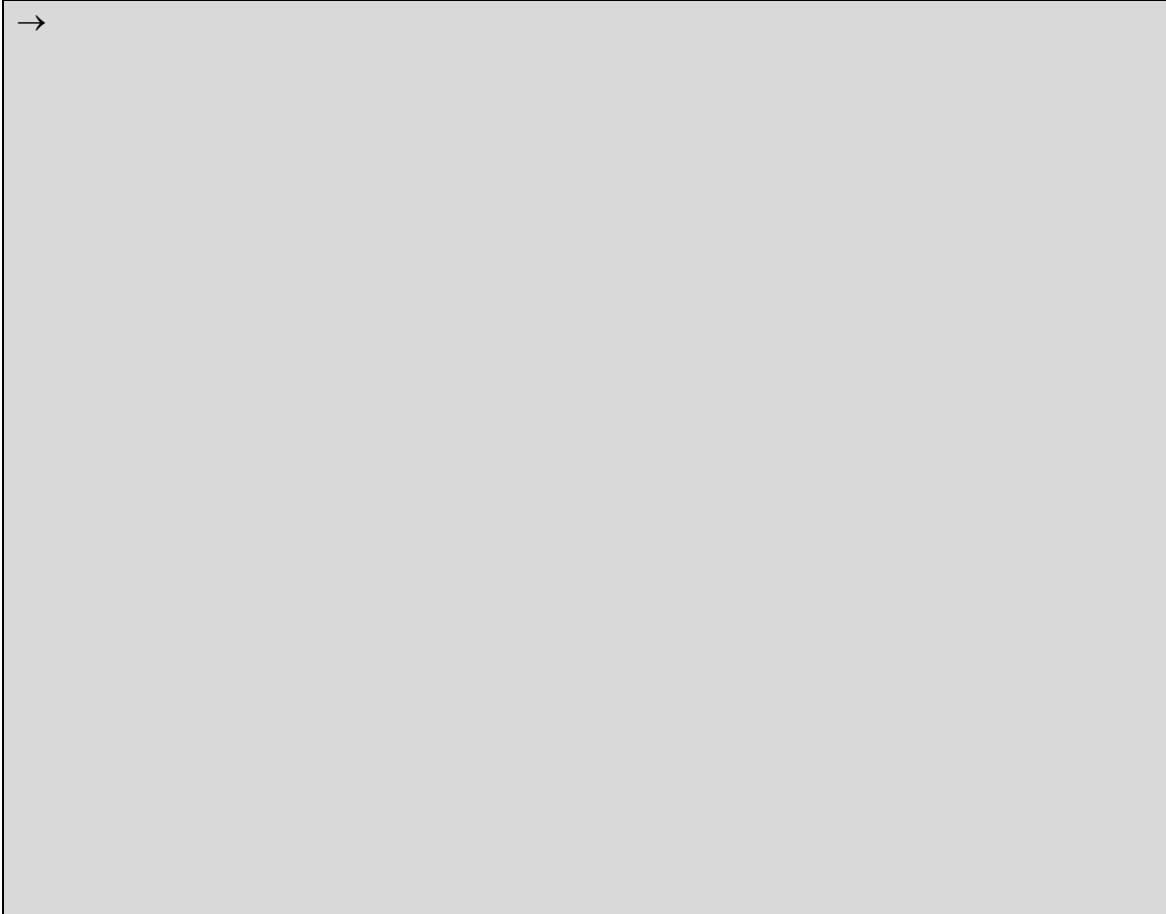
**Please specify nature of your concern:**

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**What *action* have you taken and what were the *outcomes*:**

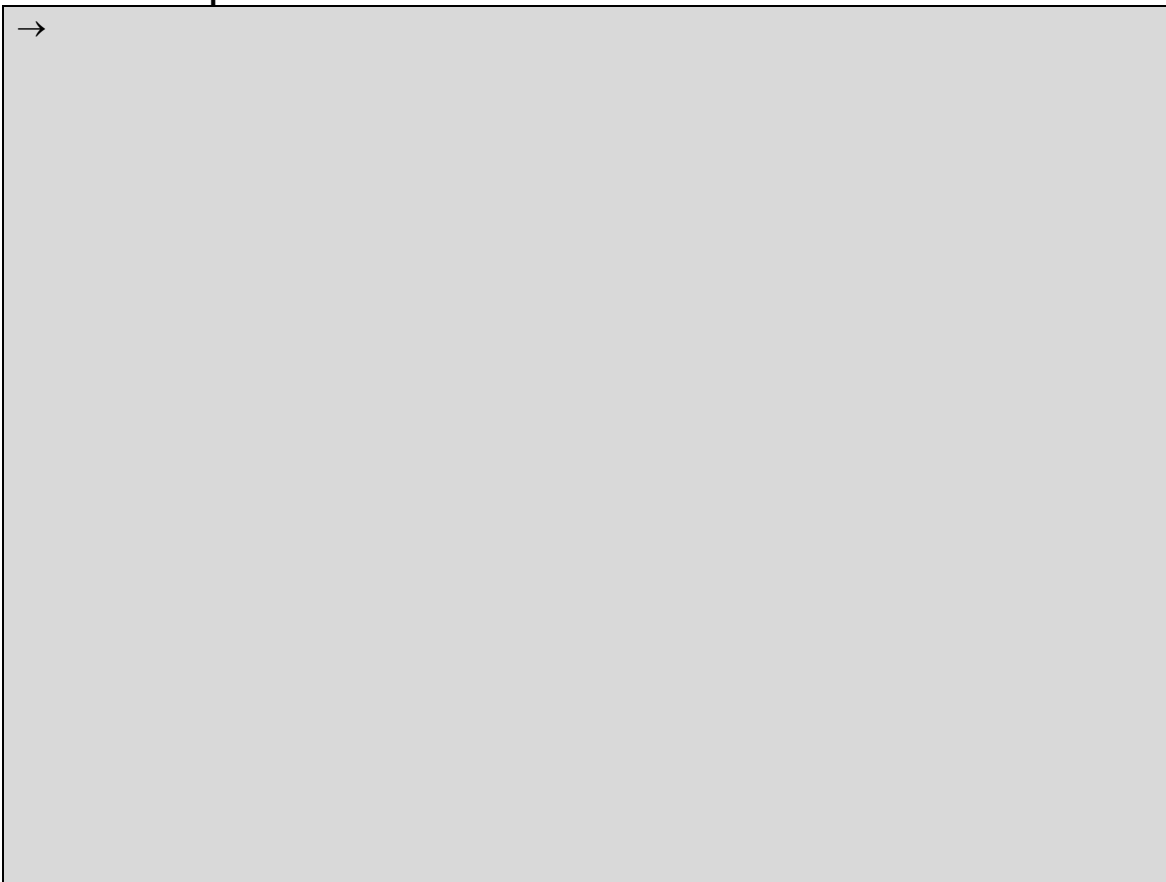
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**What outcomes would you like for the young person? Using the online Case Management Services Directory please indicate how the service or services below can help achieve these outcomes.**

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**Please tick the priority service which is requested:**

Services marked with (#) require additional supplementary information – please refer to Service Directory. If you believe more than one service is needed please specify in the 'outcomes' box above which additional services may be required and provide any additional information that may be required for referral to these services.

- |  |                          |                                     |                          |  |                          |
|--|--------------------------|-------------------------------------|--------------------------|--|--------------------------|
| Looked After Children<br>Education Service                         | <input type="checkbox"/> | Social Care                         | <input type="checkbox"/> | #Education Welfare Service               | <input type="checkbox"/> |
| Area SENCO   | <input type="checkbox"/> | #Home & Hospital Tuition<br>Service | <input type="checkbox"/> | #County Psychology                       | <input type="checkbox"/> |
| Parent Support Advisor   | <input type="checkbox"/> | Children with Disabilities          | <input type="checkbox"/> | #Emotional & Behavioural<br>Support Team | <input type="checkbox"/> |
| #Specialist Advisory<br>Teaching Services                          | <input type="checkbox"/> | #Pupil Referral Unit                | <input type="checkbox"/> | Adoption Support Team                    | <input type="checkbox"/> |
| #Referral for Statutory Assessment of Special Educational<br>Needs | <input type="checkbox"/> | #Resourced IEP                      | <input type="checkbox"/> |  | <input type="checkbox"/> |

Other Service – please specify:

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**Please indicate what supporting information is attached:**

- |  |                          |  |                          |   |                          |
|--|--------------------------|--|--------------------------|---|--------------------------|
| GP / Doctor's Report, inc:<br>any relevant medical<br>information    | <input type="checkbox"/> | Systematic Behaviour<br>Monitoring (e.g. Log / Diary,<br>ABC Charts etc) | <input type="checkbox"/> | Most recent/appropriate<br>standardised attainments | <input type="checkbox"/> |
| Evidence of Child /<br>Young Person's Views                          | <input type="checkbox"/> | Evidence of Parental Views   | <input type="checkbox"/> | Consent for SEN<br>Assessment                       | <input type="checkbox"/> |
| Intervention Plan (i.e.<br>IEP, PSP, PEP,<br>Provision Map or other) | <input type="checkbox"/> | Completed CAF Pre-<br>assessment Checklist / CAF<br>Form                 | <input type="checkbox"/> | Attendance  | <input type="checkbox"/> |
|  |                          | Community Paediatrician  | <input type="checkbox"/> | Education Welfare                                   | <input type="checkbox"/> |
| <b>Reports and<br/>Assessments:</b>                                  |                          | Educational Psychologist   | <input type="checkbox"/> | Local Health Consultant                             | <input type="checkbox"/> |
|  |                          | Specialist Advisory Teacher  | <input type="checkbox"/> | Risk Assessments                                    | <input type="checkbox"/> |

**Other - Please specify below:**

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**\*\*Please list key agencies involved:**

AGENCY	CONTACT NAME	ADDRESS	CONTACT TEL:
School/ Early Years Setting			
Health Visitor			
GP:			


### CHILD/YOUNG PERSON FURTHER INFORMATION

Has the Child or Young Person a disability?

**YES / NO**

(Please delete as appropriate)

Nature of disability:

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Is the Child or Young Person on the County CWD Database?

**YES / NO**

(Please delete as appropriate)

Is the Child or Young Person on the School SEN register?

**YES / NO**

(Please delete as appropriate)

If Yes - please indicate current stage: EARLY YEARS/SCHOOL ACTION

EARLY YEARS/SCHOOL ACTION PLUS

STATEMENT

Is the Child or Young Person a Young Carer?

**YES / NO**

### \*\*CHILD/YOUNG PERSONS ETHNICITY

White British	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Black African	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>
White & Asian	<input type="checkbox"/>	*Any other Asian Background	<input type="checkbox"/>	*Any other Black Background	<input type="checkbox"/>	*Any other Mixed Background	<input type="checkbox"/>	*Any other White Background	<input type="checkbox"/>
*Any other Ethnic Group	<input type="checkbox"/>	Traveller of Irish Heritage	<input type="checkbox"/>	Gypsy/Roma	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

(\*)Please specify:

Not Given

Child/Young Persons Religion:

Child/Young Persons Nationality:

Immigration Status (if appropriate):

Asylum Seeking

Refugee Status

Exceptional Leave to Remain

Home Office Registration Number:

### \*\*DETAILS OF PARENTS / MAIN CARERS

1<sup>st</sup> Main Parent/Carer:

Please Specify:

Mr/ Mrs/Miss/Other

Surname:

Date of Birth:

First Name(s):

Previous Names:

Relationship to Child:

Address:

Telephone No:

Mobile No:

Parental Responsibility  YES / NO  Interpreter / Signer Required  YES / NO  
 (Please delete as appropriate)

1<sup>st</sup> Language

**2<sup>nd</sup> Main Parent/Carer:**

Please Specify:  Surname:   
 Mr/ Mrs/Miss/Other

Date of Birth:  First Name(s):

Previous Names  Relationship to Child

Address:

Telephone No:  Mobile No:

Parental Responsibility  YES / NO  Interpreter / Signer Required  YES / NO  
 (Please delete as appropriate)

1<sup>st</sup> Language

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**\*\*DETAILS OF PARENTS IF THEY ARE NOT THE MAIN CARERS / RESIDENT WITH THE CHILD / YOUNG PERSON**

**Father:**

Please Specify:  Surname:   
 Mr/Other

Date of Birth:  First Name(s):

Previous Name(s):

Address:

Telephone No:

1<sup>st</sup> Language

Interpreter / Signer Required?  YES / NO   
 (Please delete as appropriate)

**Mother:**

Please Specify:  Surname:   
 Mrs/Miss/Other

Date of Birth:  First Name(s):

Previous Name(s):

Address

Telephone No:

1<sup>st</sup> Language

Interpreter / Signer Required?  YES / NO   
 (Please delete as appropriate)

**\*\*OTHER HOUSEHOLD MEMBERS (INCLUDING NON-FAMILY MEMBERS)**

Family Name	Given Name	DOB	Gender M/F	Relationship to Child	Tick if also referred

**\*\*SIGNIFICANT FAMILY MEMBERS – WHO ARE NOT PART OF CHILDS  
HOUSEHOLD**

Full Name	Address	Relationship	Contact No:

Are any of the main carers/parents/household members disabled?  YES /  NO

(Please delete as appropriate)

If Yes – please specify whom and the nature of disability if known:

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**INFORMATION SHARING**

Unless there is a risk of significant harm to a child (in which case Cumbria's Child Safeguarding Procedures Apply – available via [www.cumbrialscb.com](http://www.cumbrialscb.com)), or there are other statutory responsibilities, the referrer should obtain the parent/carer's consent for Cumbria Children's Services to share information with other agencies. Wherever possible the Child / Young Persons consent must be obtained. Note that this consent would include information given in the following pages.

The section below may be used to record consent. However, it should be noted that information may be shared without consent in order to protect the Child / Young person or to meet other legal responsibilities.

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### Parent/Carer Consent to Share Information

I understand that the above information is being given to Cumbria Children's Services for the purposes of it completing an assessment of my child's needs and/or carrying out its statutory duties. This will require Cumbria Children's Services to contact various organisations that know my family and me, and to meet with us to discuss the issues further. I understand I am entitled to receive a copy of the assessment when completed.

**Name:**  **Signature:**   
 (Please print)

**Relationship:**  **Date:**

**Please tick to confirm if you have parental responsibility**

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### Additional Parent/Carer Consent to Share Information

(This section can be used: if the carer above does not have parental responsibility, or a second parent with parental responsibilities wishes to be involved)

I understand that the above information is being given to Cumbria Children's Services for the purposes of it completing an assessment of my child's needs and/or carrying out its statutory duties. This will require Cumbria Children's Services to contact various organisations that know my family and me, and to meet with us to discuss the issues further. I understand I am entitled to receive a copy of the assessment when completed.

**Name:**  **Signature:**   
 (Please print)

**Relationship:**  **Date:**

**Please tick to confirm if you have parental responsibility**

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### Child / Young Persons Consent to Share Information

(Signature subject to age, ability and nature of referral)

I understand that the above information is being given to Cumbria Children's Services for the purposes of it completing an assessment of my needs and/or carrying out its statutory duties. This will require Cumbria Children's Services to contact various organisations that know my family and me, and to meet with us to discuss the issues further. I understand I am entitled to receive a copy of the assessment when completed.

**Signature**  **Date**

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**Please send completed form to appropriate address as indicated within the Case Management Service Directory, available online at:**

**<http://www.cumbriacc.gov.uk/childrensservices/casemanagement>**

**FOR COMPLETION ON RECEIPT OF SINGLE REFERRAL FORM:**

Date Received:

Reference No:  
(If Applicable)

Name:

Agency /  
Service:**OUTCOME:**

(Please tick all that apply, and/or enter further information as appropriate)

 Accepted Acknowledgement sent to referrer, date:  Not Accepted Alternate Service Secured**Please give reason if referral not accepted, or alternative service secured below:**→  

Building pride in Cumbria

