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| **Referral Form: Family Information and Resource Support Team (FIRST)**  Send completed referrals to [**FIRST@slough.gov.uk**](mailto:FIRST@slough.gov.uk) or contact FIRST on: 01753 476 589  **Any and all child protection concerns must be directed to the Front Door (Trust) via:**  **Telephone: 01753 875 362 (9am – 5pm) or 01344 786 543 (outside of these hours) or dial 999** |

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| 1. **Child / young person details** *– please fill out as fully as possible but don’t worry if some specific details are not known.* | | | | | |
| **Full name of child:** |  | | | | |
| **Any alternative name:** |  | | | | |
| **DOB:** | **Age**:       Tick if estimated: | | | **If unborn, estimated date of delivery?**  N/A until full implementation | |
| **Gender** | ***Click here to select from list*** | | | | |
| **Ethnicity** |  | | | | |
| **First language:** |  | | **Will an interpreter be required?**  ***Click here to select from list*** | | |
| **Current Home address** |  | | | | **Post code:** |
| **Previous home address (if known)** |  | | | | |
| **Telephone / Mobile** |  | | **Email:** | | |
| **School / Pre-school** |  | | **Address**: | | |
| **Does the child have a disability?** | | ***Click here to select from list*** | | | |
| **If yes give details of the disability:** | |  | | | |
| **Unique Pupil Number (UPN):** | |  | | | |
| **NHS Number:** |  | | | | |

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| 1. **a) Additional information about the child or young person (including other siblings)** | | | | | | | | | |
| **Parent / carer, children and others living in the household** | | | | | | | | | |
| Last name | First name | | Relationship to child(ren) | DOB / EDD | Gender (M / F) | Ethnicity | Focus of referral Yes/No | School / preschool | Does this person hold Parental responsibility? |
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| **b) Other significant adults** | | | | | | | | | |
| Last name | | First name | Relationship to child(ren) | DOB | Ethnicity | Address | | | Does this person hold PR |
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| 1. **In order to consider what additional help is needed please answer the following:** | | |
| 1. a) Has the Thresholds Criteria been used to inform your decision? | | ***Click here to select from list*** |
| 1. b) Select the primary reason for the request for support | | ***Click here to select from list*** |
| 1. c) Select the secondary reason for the request for support | | ***Click here to select from list*** |
| 1. **What are you most worried about?** Please indicate the individual needs of the child(ren) and what needs to change for the child(ren) and why? What has prompted this referral now? | | |
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| 1. **What help have you or others provided to address the child or family needs? And when?** Please send us any assessments you have completed and any Team around the Child or Family meeting | | |
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| 1. **What information do you know about the parent/carer and the wider family support network?** *(include relationships, friendships, behaviour, support, stability, safety, language, mental health, substance misuse, domestic abuse etc)* | | |
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| 1. **Are there any risks we need to be aware of?** *(include if the parent or carer is difficult to work with/approach, or if there’s a history of aggression shown to professionals etc)* | | |
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| 1. **Details of other agencies working with the family** | | |
| **GP** | | |
| **Name**  **Address**  **Telephone number** |  | |
| **Health visitor / School Nurse / Midwife** | | |
| **Name**  **Address**  **Telephone number** |  | |
| **Other professional / agency (insert agency name here)** | | |
| **Name**  **Address**  **Telephone** |  | |
| **Other professional / agency (insert agency name here)** | | |
| **Name**  **Address**  **Telephone** |  | |
| **Other professional / agency (insert agency name here)** | | |
| **Name**  **Address**  **Telephone** |  | |

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| 1. **Have any referrals to other services been made? If so please list and date them** |
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| 1. **CONSENT** | | |
| *It is a legal requirement that parents/carers have consented to this request for additional support but please discuss with us if there are difficulties with engagement*. | | |
| **What is the view of the parent/carer about this referral and what needs have they identified for their child(ren)?** | | |
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| **Has consent been given for this referral from the Parent / Carer: *Click here to select from list***  **Written/Verbal: *Click here to select from list*** | | **Has consent been given for this referral from the Child / young person: *Click here to select from list***  **Written/Verbal: *Click here to select from list*** |
| **Who gave consent?** |  | |

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| 1. **About the Referrer** | | | | |
| **Name of referrer** |  | Job Title |  | |
| **Agency** |  | Address |  | Post code: |
| **Telephone number** |  | Email |  | |
| **Date of referral** |  | Signature |  | |

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| **Any other comments or information that would help us respond to this referral?** |
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**FIRST referrals must be completed in full, with consent and sent to:** [**FIRST@slough.gov.uk**](mailto:FIRST@slough.gov.uk)**. If a school needs help completing the form please call the FIRST team on: 01753 476 589**