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| **Referral Form: Family Information and Resource Support Team (FIRST)**Send completed referrals to **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**
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| *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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**All child protection concerns must be directed to the Front Door on Telephone: 01753 875 362 (9am – 5pm) or 01344 786 543 (outside of these hours)**

**FIRST referrals must be completed in full, with consent and sent to:** **FIRST@slough.gov.uk****. If a school needs help completing the form please call the FIRST team on: 01753 476 589**