**CHANGING FACES**

*OFFICE USE ONLY* – **FAMILY NUMBER**

**REFERRAL FORM**

***Supporting families where children are at risk of***

***or have experienced child sexual exploitation***

*Please complete all sections or your referral may be returned.*

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| If this referral is being made on behalf of a family, it must be made with the consent of the family and **we cannot proceed without this**  **P***lease tick to confirm parent(s)’ consent and complete signature boxes overleaf 🖵* |
| Is the young person experiencing or at risk of child sexual exploitation aware of this referral?  YES/NO (*delete as appropriate)* |

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| --- | --- | --- | --- | --- | --- |
| **Information about the parents/carers involved with the child(ren)** | | | | | |
| **Name of Family:** | | | | | |
| **Address (inc post code):** | | **All telephone numbers:** | | | |
| **Relationship to Child(ren)** | **Name, DOB and Ethnic Origin\*** | | **Main Carer**  **√** | **Parental**  **Responsibility √** | **Resident in family home √** |
| **Mother/Partner** |  | |  |  |  |
| **Father/Partner** |  | |  |  |  |
| **Other Main Carer** |  | |  |  |  |
| **Referrer Information** | | | | | |
| **Referrer Name:** | | **Address (inc postcode)** | | | |
| **Agency:** | | **Email:** | | | |
| **Role:** | | **Tel:** | | | |
| **Other Agencies Working with the Family** | | | | | |
| **Family Doctor Name:**  **Surgery Address:**  **Tel:** | | **Name/Role:**  **Agency:**  **Tel:**  **Email:** | | | |
| **Health Visitor:**  **Tel:**  **Email:** | | **Name/Role:**  **Agency:**  **Tel:**  **Email:** | | | |
| **Why are you referring the family to FACES?** | | | | | |
| ***Does the family give us permission to contact other agencies with a view to supporting them?*** | | | | | |
| ***Are there any Health and Safety issues we need to consider?*** | | | | | |

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| **Issues Present in Current Situation (please √ all that apply)** | | | | | | | | |
| Lone Parent | Substance Abuse | Domestic Abuse | Mental Health Issues | Learning Disability | Physical Disability | Post Natal Depression | Interpreter Needed | Teen  Pregnancy |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Information about the Child(ren)** | | | | | | | | |
| **No.** | **Name** | | | | **DOB** | | **Gender**  **(M/F)** | **Ethnic Origin (please state)** |
| **C1** |  | | | |  | |  |  |
| **C2** |  | | | |  | |  |  |
| **C3** |  | | | |  | |  |  |
| **C4** |  | | | |  | |  |  |
| **C5** |  | | | |  | |  |  |
| **C6** |  | | | |  | |  |  |
| **Information about any plans family are subject to** | | | | | | | | |
| **Child**  **No.** | | **CAF/EHA (Y/N)** | **TAF/TAC**  **(Y/N)** | **CIN**  **(Y/N)** | **CP**  **(Y/N)** | **Details of Lead Professional (if applicable)** | | |
| **C1** | |  |  |  |  |  | | |
| **C2** | |  |  |  |  |  | | |
| **C3** | |  |  |  |  |  | | |
| **C4** | |  |  |  |  |  | | |
| **C5** | |  |  |  |  |  | | |
| **C6** | |  |  |  |  |  | | |

***Family needs –*** *In order that we can offer the best support, please complete the following table indicating why a family need help in the areas stated. This information, together with that gathered at initial assessment (which will take place after completed referral form received) serves to inform our tailored plan of support.*

|  |  |  |
| --- | --- | --- |
| **Family Need** | **√** | **If ticked, please state why this is a need** |
| Risk of Child Sexual Exploitation |  |  |
| Supporting .  Child(ren)’s Emotional Wellbeing |  |  |
| Managing Boundaries and Behaviour with Confidence |  |  |
| Identifying Appropriate Network of Support (for Parents and Children) |  |  |
| Maintaining Healthy Family Relationships |  |  |
| Parent(s) Mental Health |  |  |

We cannot proceed with support until we have received this completed referral form (*which needs to be completed within one calendar month from date of enquiry*). We will try to respond to you within two weeks to let you know about progress of this referral.

* **Self referrals** – Our family support practitioner will be in touch to arrange an initial assessment with you at your home where they will discuss with you how best we can support you.
* **Professionals -** we will remain in touch whilst we support this family and will let you know when support ends.

***We cannot proceed without parent’s consent so please ensure parent(s) sign below.***

***If verbal consent given, please state this clearly below.***

|  |  |
| --- | --- |
| Parent’s Signature: | Date: |
| Referrer’s Signature:  (if applicable) | Date: |