SHARED REFERRAL FORM

(All Health Professionals Generic Shared Referral Form)

1a. REFERRAL DETAILS

Name of Referrer	Agency	Designation	Postal Address (include postcode)	Email	Phone	Fax

1b. DESIGNATED CONTACT PERSON (IF DIFFERENT FROM 1a)

Name of Referrer	Agency	Designation	Postal Address (include postcode)	Email	Phone	Fax

2. REFERRAL TO

Date of Referral	Time of Referral (am or pm)	Name of worker spoken to	Designation	Is the parent/carer aware of this referral? Yes/No	Is the young person aware of this referral? Yes/No
Area/Hospital Social Work Team		**Responsible Local Authority**	**Phone**	**Is this a re-referral from your service? Yes/No**	**If yes, please enter date(s) of previous referral(s)**

A copy should be sent to Dorothy Ramsden at the Child Protection Unit, 2nd Floor Medical Records Building, Dalnair Street, Glasgow. G3 8SJ. If electronically send to dorothy.ramsden@ggc.scot.nhs.uk

3. SUBJECT OF REFERRAL

	Child's Name	Other name known by	DOB dd/mm/yy	CHI	Age	Gender (M/F)	Home Address (include Postcode)	Ethnicity	Religion
1									
2									
3									

	Preferred Language	Interpreter required (specify)
1		
2		
3		

Child Affected by Disability

Description	Communication Assistance required (specify)

4. FAMILY DETAILS

Mother's Name	DOB (If Known)	Other name known by	Current Address (If different from child)

Father's Name	DOB (if known)	Other name known by	Current Address (if different from child)

4. FAMILY DETAILS (cont'd)

Family Address (include postcode)	Phone (if known)	Is Child Currently Resident at this Address? Yes/No	If No, state Address (include postcode)

Principal Carer's Details (if different from Mother/Father)

Name	DOB (if known)	Relationship to Child	Address (including postcode)	Type of Residence (if not at home)

Other Adults in Household

Name	DOB (if known)	Relationship to Child

Any Other Significant Adult(s) (if known, please include contact details)

Name	DOB (if known)	Address	Phone	Relationship to Child

Siblings not subject to referral

Child's Name	Other name known by	DOB dd/mm/yy	CHI	Age	Gender	If in relation to unborn baby or mother is pregnant – Estimated Date of Birth

5. SUMMARY OF CONCERNS

FOR ALL OTHER REFERRALS PLEASE COMPLETE THE FOLLOWING

IF APPLICABLE PLEASE COMPLETE

Suspicion/risk of (factors relating to the child)	
Absconding	☐
Child Safety	☐
Education	☐
Emotional Care/Development	☐
Health – Illness/Disability	☐
Outwith Parental Control	☐
Physical Care/Neglect	☐
Self harm	☐
Sexual Exploitation	☐
Offender Behaviour	☐
Substance Misuse	☐
Other (please specify below)	☐

Suspicion/risk of (factors relating to parents/ carers)	
Alcohol Abuse	☐
Asylum Seekers/Refugees	☐
Domestic Abuse	☐
Drug Abuse	☐
Housing/Accommodation	☐
Learning Disability	☐
Mental Illness	☐
Parenting	☐
Physical Illness	☐
Poverty/Financial	☐
Other (please specify below)	☐

Suspicion/risk of	
Physical Injury	☐
Emotional Abuse	☐
Physical Neglect	☐
Non-Organic Failure to Thrive	☐
Sexual Abuse	☐

6. REASON FOR REFERRAL/REQUEST FOR SERVICES: (please record reason for concern and how this impacts on child. If applicable, please indicate alleged abuser. Indicate what action, if any, you have taken prior to the referral).

7. AGREED ACTIONS (Actions agreed during phone referral)

8. AGENCY INVOLVEMENT

Health	**GP's Name**	**Address**	**Phone**	**Email**
Health Visitor/School	**Name of Health Visitor/School Nurse**	**Address**	**Phone**	**Email**
Education (Nursery / School)	**Name of School and Contact Person**	**Address**	**Phone**	**Email**
Any Other Agencies (if known)	**Name of Agency and Contact Person**	**Address**	**Phone**	**Email**

Signature of Referrer ..... **Please print name** .....

Date .....

Signature of Line Manager (if applicable) ..... **Please print name** .....

SHARED REFERRAL FORM

Acknowledgement of Child Welfare/Protection Referral To Social Work Services

Social Work Services use only (Return to Dorothy Ramsden at dorothy.ramsden@ggc.scot.nhs.uk within 5 working days)

REFERER'S NAME, DESIGNATION AND BASE:

SUBJECT OF REFERAL'S NAME AND DOB/CHI:

DATE OF REFERRAL:

SWID NO:

REQUEST TREATED AS:

OUTCOME OF REFERRAL/REQUEST FOR SERVICES:

ANY OTHER COMMENTS:

NAME/DESIGNATION:

SIGNATURE:

DATE:

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