

Hertfordshire Child Protection Referral Form



This form should only be used when a child or young person is at risk of significant harm

If you have concerns that a child or young person is at **immediate** risk of harm, please contact the emergency services on 999

Please complete this form as fully as possible. However, do not delay the referral in a situation where this may place the child at further risk of significant harm.

What is the reason for this referral?

1. Risk of significant harm to the child
2. Expectation of service
3. Desired outcome

How was this risk identified? Include:

1. where the incident took place
2. who was involved (if appropriate)
3. time and date of the incident

Please describe if child has visible injuries

Please give details of the steps already taken to make the child/young person safe.
Include any contact with emergency services or a social worker.

Child / young person / unborn baby details

Forename(s):

For unborn baby insert "UBB"

Date of birth / EDD: / /

Surname:

For unborn baby insert mother's surname

Gender: Male ☐ Female ☐ Unknown ☐

Current address:

Postcode:

Disability: No ☐ Yes ☐ Please supply details

Add home address if different:

Postcode:

Immigration issues?

Asylum seeker: Yes ☐ No ☐

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Child's first language:

write N/A if pre-verbal

Religion:**Reference number:**

(e.g. NHS Number, Unique Pupil Number)

Ethnicity:**Name, address and contact details of GP:**

Postcode:

Name, address and contact details of health visitor/school nurse:

Postcode:

Name of early years setting/school/college and contact person:**Parent/carers details****Please give names of child's primary carer(s) and their relationship to the child/young person**

Full name	Address (if different from the child)	DOB	Gender	Parental Responsibility
	Postcode: Tel:	DD/MM/YY	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
	Postcode: Tel:	DD/MM/YY	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>

Do the parent/carers have a disability?No ☐ Yes ☐ please give details**First language:**Is an interpreter /signer required? Yes ☐ No ☐**Family composition/significant others**

Full name	Address, postcode, and Tel	DOB if known	Relationship to child/ren named overleaf	Gender	If a child, are you referring as well?
		DD/MM/YY		M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		DD/MM/YY		M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		DD/MM/YY		M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		DD/MM/YY		M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

		DD/MM/YY		M <input type="checkbox"/>	Yes <input type="checkbox"/>
				F <input type="checkbox"/>	No <input type="checkbox"/>
		DD/MM/YY		M <input type="checkbox"/>	Yes <input type="checkbox"/>
				F <input type="checkbox"/>	No <input type="checkbox"/>
		DD/MM/YY		M <input type="checkbox"/>	Yes <input type="checkbox"/>
				F <input type="checkbox"/>	No <input type="checkbox"/>

Other agencies/services involved with this child/young person/family e.g. CAMHs, adult services etc

Name of professional and organisation	Contact details - Please include address, postcode, Tel, email	Brief description of work undertaken or ongoing support if known

Has a CAF (Common Assessment Framework) been completed on this child or young person?

No ☐ Yes ☐ Please give the Lead Professional's name and contact details

Information sharing

Professionals should share their concerns about a child/ren with the family, unless doing so might place the child/ren at further risk of significant harm. You will need to make a professional judgment on informing the child or young person of this referral.

Form completed by: (full name, job title and agency/service) Date: DD/MM/YY	Who has been informed of this referral?
Contact details: (include email address and contact number)	Is there any parent/carer/significant person named on this form who has not been informed of this referral and why?

Send completed form to:

Email: protectedreferrals.cs@hertscgcsx.gov.uk or
protectedreferrals.cs@hertfordshire.gov.uk

Post: Customer Service Centre, PO Box 153, Stevenage, SG1 2GH

For urgent child protection referral also ring 0300 123 4043

Confidentiality: This form contains personal information.

Please ensure secure document storage and safe information sharing.