REFERRAL AND INITIAL INFORMATION RECORD

SSD Case Numbers _____ Date referral received |__|__|__|__|__|__|

Is the parent/carer aware of the referral? Yes ☐ No ☐ Re-Referral ☐

Child/Young Person's name, address and responsible LA

Family name _____ Forenames _____ Dob _____ Gender _____

Address _____

Postcode _____ Tel. _____

Current address if different from above _____

Postcode _____ Tel. _____

SSD Team _____ Responsible local authority _____

Child/Young Person's principal carers

Name	Relationship to child/young person	Parental Responsibility
_____	_____	Yes ☐ No ☐
_____	_____	Yes ☐ No ☐

Referred by _____ Agency/rel. to child/young person _____

Address _____

Postcode _____ Tel. _____

Does referrer wish to remain anonymous Yes ☐ No ☐

Child/young person's religion _____ Child/young person's ethnicity: _____

Caribbean	☐	Indian	☐	White British	☐	White and Black Caribbean	☐	Chinese	☐
African	☐	Pakistani	☐	White Irish	☐	White and Black African	☐	Any other ethnic group	☐
Any other Black background	☐	Bangladeshi	☐	Any other White background	☐	White and Asian	☐	Not given	☐

Any other Asian background ☐ Any other mixed background ☐

If other, please specify _____ Child's first language _____ Parent(s) first language _____

Is an interpreter or signer required? Yes ☐ No ☐ Has this been arranged? Yes ☐ No ☐

Other household members (including non-family members)

Surname	Forename	DoB	SSD case number if appropriate	Relationship to child	Tick if also referred to SSD

Significant family members who are not members of child's household

Name _____ Name _____

Relationship _____ Relationship _____

Address _____ Address _____

Tel. _____ Tel. _____

Information on statutory status

	Yes	*No*	*Please give details:*
Child/young person or other child(ren)/ young person(s) in family is/has on a disability register	☐	☐	Name Date(s)
Child/young person or other child(ren)/ young person(s) in family is/has on a child protection register	☐	☐	Name Date(s) Category
Child/young person or other family member(s) has/have been looked after a local authority	☐	☐	Name Date(s)

Other SSD cases associated with the child/young person

Name _____ Case No. _____ Name Case No.

Name _____ Case No. _____ Name _____ Case No. _____

Key agencies *(please tick if currently working with the family)*

G.P.	☐	Tel. _____	H.V.	☐	Tel. _____
Nursery	☐	Tel. _____	E.W.O.	☐	Tel. _____
School	☐	Tel. _____	Police	☐	Tel. _____
Y.O.T.	☐	Tel. _____	Dentist	☐	Tel. _____
Community Mental Health	☐	Tel. _____	Community Paediatrician	☐	Tel. _____
School Nurse	☐	Tel. _____	Other	☐	Tel. _____

Reason for referral/request for services:

Name of staff member completing this referral _____ Signature _____ Date ___/___/___

Further action:

Provision of information and advice ☐

Initial assessment (to be completed within 7 working days) ☐

Practice note: ensure this referral is collated with previous referrals or files

Referral to other agencies (please state which) ☐

_____

No further action ☐

Reason for Further Action

Name of Team Manager _____ Signature _____ Date ___/___/___

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