

Child and Family Consultation Service - Referral Form

~Please enclose most recent assessment of young person~

INFORMATION about Referred Person:

NHS No: _____					
Surname: _____		DOB: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			
First Name: _____		Sex: M F			
Home Address: _____ _____					
Tel: (Home) _____		Tel: (Work) _____			
First Language: _____		Interpreter Needed: Y N			

FAMILY MEMBERS:

Name of Parent/Carer: _____

MAIN CARER(S) (please specify):

- | | |
|--|--|
| Mother <input type="checkbox"/> | Father <input type="checkbox"/> |
| Grandmother <input type="checkbox"/> | Grandfather <input type="checkbox"/> |
| Step Parent <input type="checkbox"/> | Guardian <input type="checkbox"/> |
| Foster Parent <input type="checkbox"/> | Resident Key Worker <input type="checkbox"/> |

Other Family Members:

Name	DOB	Relationship to Referred Person	Address if different from above

GP DETAILS:

Name: _____	
Address: _____	
Postcode: _____	Tel: _____

SCHOOL DETAILS:

Name: _____	
Address: _____	
Postcode: _____	Tel: _____

REFERRED BY:

Name: _____ Designation: _____

Team Name/Organisation: _____

Address: _____

Postcode: _____ Tel: _____

URGENCY OF REFERRAL:

Emergency (Same Day)

Urgent

Non-Urgent

REASON FOR REFERRAL:

What is the nature and background of the problem?

(please use separate sheet if necessary)

In what ways do you think CFCS can help at this point?

(please use separate sheet if necessary)

Would you continue to be involved, and if so, how?

How do the family view this referral?

In our experience the success of our work largely depends on the active participation of parents/carers. What in your view is the family's motivation and ability to engage?

LEGAL ISSUES

Is any member of the family subject of Child Protection Registrar Care Proceedings?

Is any member of the family subject to Mental Health Act 1983 Section 2?
If so, please give details:

Is any member of the family subject to Parental Restraining Order?
If so, please give details:

Who has parental responsibility for the referred person?

Other court proceedings?

OTHER AGENCIES INVOLVED:

Signed: _____ **Date of Referral:** _____

Name (Block Capitals): _____

Return to:

*Child and Family Consultation Service
Woodberry Down Unit
John Scott Health Centre
Green Lanes, London N4 2NU
Tel: 020 8809 5577
Fax: 020 8802 8678*

*Child and Family Consultation Service
Lower Clapton Health Centre
36 Lower Clapton Road
London E5 0PD
Tel: 020 8986 7351
Fax: 020 8985 8115*

*Child and Family Consultation Service
St Leonard's Primary Care Centre
55 Nuttall Street
London N1 5LZ
Tel: 020 7301 3414
Fax: 020 73013355*

ETHNICITY (As defined by user)

DESCRIPTION	✓	DESCRIPTION	✓
Not stated	<input type="checkbox"/>	Any other Asian background	<input type="checkbox"/>
Refuse to state	<input type="checkbox"/>	African Asian	<input type="checkbox"/>
White: British		Kashmiri other	<input type="checkbox"/>
English	<input type="checkbox"/>	Nepali	<input type="checkbox"/>
Scottish	<input type="checkbox"/>	Sinhalese	<input type="checkbox"/>
Welsh	<input type="checkbox"/>	Sri Lankan Tamil	<input type="checkbox"/>
Any other White British	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>
White: Irish		Caribbean	<input type="checkbox"/>
Irish	<input type="checkbox"/>	African	
Traveller of Irish decent	<input type="checkbox"/>	Angolan	<input type="checkbox"/>
White: Any other White background		Congolese	<input type="checkbox"/>
Albania	<input type="checkbox"/>	Ghanaian	<input type="checkbox"/>
Bosnian-Herzegovinian	<input type="checkbox"/>	Nigerian	<input type="checkbox"/>
Croatian	<input type="checkbox"/>	Sierra Leonean	<input type="checkbox"/>
Greek	<input type="checkbox"/>	Somali	<input type="checkbox"/>
Greek Cypriot	<input type="checkbox"/>	Sudanese	<input type="checkbox"/>
Kosovan	<input type="checkbox"/>	Other Black African	<input type="checkbox"/>
Italian	<input type="checkbox"/>	Any other Black background	
Portugese	<input type="checkbox"/>	Black European	<input type="checkbox"/>
Serbian	<input type="checkbox"/>	Black North American	<input type="checkbox"/>
Turkish	<input type="checkbox"/>	Other Black	<input type="checkbox"/>
Turkish Cypriot	<input type="checkbox"/>	Chinese	
White Eastern European	<input type="checkbox"/>	Hong Kong Chinese	<input type="checkbox"/>
White Western European	<input type="checkbox"/>	Malaysian Chinese	<input type="checkbox"/>
Gypsy/Roma	<input type="checkbox"/>	Singaporean Chinese	<input type="checkbox"/>
Other White	<input type="checkbox"/>	Taiwanese	<input type="checkbox"/>
Mixed:		Other Chinese	<input type="checkbox"/>
Mixed White and Black Caribbean	<input type="checkbox"/>	Any other ethnic group	
Mixed White and Black African	<input type="checkbox"/>	Afghanistani	<input type="checkbox"/>
White and Pakistani	<input type="checkbox"/>	Arab	<input type="checkbox"/>
White and Indian	<input type="checkbox"/>	Egyptian	<input type="checkbox"/>
White and any other Asian background	<input type="checkbox"/>	Filipino	<input type="checkbox"/>
Asian and any other ethnic group	<input type="checkbox"/>	Iranian	<input type="checkbox"/>
Asian and Black	<input type="checkbox"/>	Iraqi	<input type="checkbox"/>
Asian and Chinese	<input type="checkbox"/>	Japanese	<input type="checkbox"/>
Black and any other ethnic group	<input type="checkbox"/>	Korean	<input type="checkbox"/>
Black and Chinese	<input type="checkbox"/>	Kurdish	<input type="checkbox"/>
Chinese and any other ethnic group	<input type="checkbox"/>	Latin American	<input type="checkbox"/>
White and any other ethnic group	<input type="checkbox"/>	Lebanese	<input type="checkbox"/>
White and Chinese	<input type="checkbox"/>	Libyan	<input type="checkbox"/>
Other mixed background	<input type="checkbox"/>	Malay	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Moroccan	<input type="checkbox"/>
Pakistani		Polynesian	<input type="checkbox"/>
Mirpuri Pakistani	<input type="checkbox"/>	Thai	<input type="checkbox"/>
Kashmiri Pakistani	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>
Other Pakistani	<input type="checkbox"/>	Yemeni	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>	Other ethnic group	<input type="checkbox"/>
		Other (Please specify) _____	<input type="checkbox"/>