**#SEEN @ FACES**

*OFFICE USE ONLY* – **FAMILY NUMBER**

**REFERRAL FORM**

**BEDFORD BOROUGH**

*Supporting families whose children are at risk of/or have experienced child sexual exploitation, child criminal exploitation and sexual violence (CSE, CCE, SV)*

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

|  |
| --- |
| ***It would be beneficial if you could provide the most up to date CSE Risk Assessment to accompany this referral if applicable*** |
| This referral will only be accepted if the family consents to it. Do you have consent from the young person’s main carer to make this referral and have you explained FACES role YES/NO |
| Is the young person concerned aware of this referral and are they aware of FACES role? YES/NO  |

|  |
| --- |
| **Information about the parents/carers involved with the child(ren)** |
| **Name of Family:** |
| **Address (inc post code):** | **All telephone numbers:****Email address:** |
| **Relationship to Child(ren)** | **Name,****DOB****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:**  |
| **Young Person’s School/College/Place of Education or are they NEET?** |
| **Name and Address of School etc** | **Telephone number****Email address** |
| **Other Agencies Working with the Family** |
| **Family Doctor Name:****Surgery Address:****Tel:** | **Name/Role:****Agency:****Tel:****Email:** |
| **Please complete an additional sheet if more agencies are involved:** |
| Can you tell us if there anything we need to know in terms of arranging support, eg parents’ shift work etc, no access to visits in school etc |
| 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?  |
| **Please indicate family need below**  | **Parent** | **CYP** | **N/A** |
| * Exploitation Awareness (CSE, CCE, SV)

 Why? |  |  |  |
| * Support with strategies to exit/reduce risk of exploitation

Why? |  |  |  |
| * Support to improve family communication

Why? |  |  |  |
| * Support to establish effective network of support

Why? |  |  |  |
|

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

 |
|  |

|  |
| --- |
| **Information about the Child(ren)** |
| **ChildNo.** | **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** |  |  |  |  |  |
| If a family are subject to a plan, please send a copy of the plan with this referral to avoid the need for a family to have to repeat their story to us. All information including that gathered at our initial visit will serve to inform our tailored plan of support. |

We cannot proceed with support until we have received this completed referral form. If it is incomplete we may return it to you. All referrals are subject to capacity and we aim to respond to you within two weeks regarding progress.

* **Self referrals** – Our family support practitioner will be in touch on receipt of this referral to inform you of next steps.
* **Professional Referrals -** We will keep you informed of the progress of this referral and will let you know when support ends.

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

***If verbal consent given, please state this clearly below. Failure to do so may result in delays in service provision.***

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

Return to office@facesbedford.org (Tel: 01234 270601)

or by post to FACES, Church Lane Community Centre, 147 Church Lane, Bedford MK41 0PW