NHS Highland

CHILD PROTECTION REFERRAL (GEN 1)

(For use by NHS Highland personnel in respect of unborn children/children aged under 16years)

Unborn/Child Information

Name……………………………………………

Date of Birth/EDD……………………………

Address………………………………………..

……………………………………………………..

Hospital & Consultant & Ward ……….................

……………………………………………………............

GP……………………………………………………

Health Visitor/School Nurse………………………

School Attended……………………………………..

Patient Telephone Number(s) ………………………………………………………………………………

DETAILS OF FAMILY BEING REFERRED

Parent/Carer's Name……………………….. **DOB** ………….........

Parent/Carer's Name……………………………………………………………… **DOB** ……………………

Relationship to Child ……………………………. **Relationship to Child** ……………………………….

Address (If different to Child's)……………………………………………………………………………..

…………………..………………………………………………………………………………………...

Other Children's Names:

1………………………………………………. **DOB** ………………………. **CHI** ………………

2………………………………………………. **DOB** ………………………. **CHI** ………………

3………………………………………………. **DOB** ………………………. **CHI** ………………

Other Household Members (Include DOB)…………………………………………………………

REFERRAL TO SOCIAL SERVICES

- **Name of Social Worker Spoken to**…………………………………………………………………..
- **Date** ………………………………………… **Time** ……………………………………………**hours**
- **Name of Social Work Office Gen 1 Sent to** ……………………………………………………….

REFERRAL FORM COPIED TO: (please circle)

Patient Records/A&E Records	**Yes**	**No**
Hospital/Community Child Protection Advisor	**Yes**	**No**
Health Visitor/School Nurse	**Yes**	**No**
General Practitioner	**Yes**	**No**
Allied Health Professional	**Yes**	**No**
Hospital/Community Paediatrician	**Yes**	**No**
Other: (eg CPN/Community Staff/Hospital Staff)	**Yes**	**No**

Specify………………………………………………………………………………………………….

……………………………………………………………………………………………………..

SIGNIFICANT CONCERNS IDENTIFIED (Child Focused)

(NB The Child Protection Advisor in Health must be informed of all Child Protection concerns. Please photocopy this form to the Child Protection Advisor)

1………………………………………………………………………………………………

2………………………………………………………………………………………………

3………………………………………………………………………………………………

SUMMARY OF EVENTS LEADING TO REFERRAL

Include known relevant past and present medical and social history and current residency.
Consider strengths and pressures.

Signature ……………………………………………… **Date**…………………………………………

Name (Print) ……………………………………………. **Telephone Number** ………………………

Designation……………………………………………… **Base/Ward/Department** …………………

To be completed by recipient: (please circle)

How have you acknowledged receipt of this referral?

Telephone **Email** **Letter** **Other (specify)**……………………………

Available on NHSH Intranet
(Gen 1 Form Amended June 2008: Version 2)