

Integrated

Referral Form

**Do you have any Child Protection, Adult at Risk or allegations/concerns of Professional Abuse?**

If yes, the concerns need to be shared immediately by telephone with:

* Relevant partner agency
* Police (999/101)
* Social Services (number at the end of form)
* NHS Corporate Safeguarding (01639 683164)

**IT IS EVERY PERSONS RESPONSIBILITY TO REPORT A CONCERN**

For 3rd sector/Universal Services, please visit <https://www.dewis.wales>

Do you consider this referral to be for:

* Early Intervention and Prevention, including Team Around the Family (TAF) and Community Support Services [ ]
* Safeguarding Concerns [ ]
* Adult at Risk [ ]

|  |
| --- |
| *Place X in the box to confirm this has been discussed and agreed with the referred* *person / child / parent.* |
| The person confirms that the details given in this referral form have been discussed and shared with them and understand the reasons for the referral. |  |
| The person understands that the referral will be submitted to the Single Point of Contact (SPOC)/IAAto consider next steps (i.e. Information, Advice, Assistance or Assessment). |  |
| The person understands that information gained about them as part of this referral, assessment and ongoing support will be shared with key partner agencies. |  |
| The person authorises the SPOC/IAA contacting key agencies as listed on page 3, for the purpose of making enquiries about my support needs.  |  |
| If no authorisation has been given, please state reason(s) below why this should proceed to a referral. If person lacks mental capacity please detail in Section 5.  |
|  |

* Allegations/Concerns of Professional Abuse[ ]

**AUTHORISATION**

|  |  |
| --- | --- |
| **Name and/or Signature of the person referred**(if there is a power of attorney for health and welfare in place please gain their consent and ask them to sign on behalf of the person)(if the child is under 18 please ask a parent / guardian to sign below)(children 16 or above who do not have a parent / guardian can sign themselves) | **Date** |
|   |  |

|  |  |
| --- | --- |
| **Section 1**  | **Referrer Details** |
| **Date of referral** |  |
| **Name of referrer (including designation)** |  |
| **Agency details (including contact address)** |  |
| **Full Telephone number** |  |
| **Email address** |  |

|  |  |
| --- | --- |
| **Section 2**  | **Details of the Individual(s)** |
| **Name** | **Gender** | **D.O.B** | **Language** | **Ethnicity** | **Status** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Full Home Address****(If the individual is in hospital please also state which hospital and ward)** |  |
| **Home Telephone Number** |  | **Mobile Telephone Number** |  |
| **Preferred Language** |  |
| **Tenure, accessibility to the home and accommodation type.** | (This information is particularly important if referring for aids and adaptations to the home) |
| **Please confirm if the property is:** |
| Privately Owned |  | Privately Rented |  | Tai Tarian Property |  |
| For other property type, please specify: |
| **Does the person consider themselves to have a disability?**   | **YES -** If yes, please give full details in the ‘Persons Circumstances’ section below. |
|  |
| **Section 3**  | **Family Members** |
| **Family****Member** | **Main Carer/ Emergency Contact/ PR** | **First Name** | **Surname** | **DOB** | **Eligibility** | **Address and Telephone No** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Section 4**  | **Key Agency involvement with the person and their family** **(e.g. school, GP please state if previous or current)** |
| **Agency** | **Contact Name** | **Telephone No.** | **Previous/Current** | **Supporting** *(name of family member)* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Section 5** |
| 1. **Persons Circumstances (Reasons for referring)**
 |
|  |
| 1. **Personal Outcomes**

 *What outcomes does the person want to achieve?* *What outcomes do the carers / family want to achieve?* *What support do you think the person requires?* |
|  |

|  |
| --- |
| 1. **Strengths/ Capabilities–** *Please identify what strengths you or the person / parent / child has identified.*
 |
|  |
| 1. **Risks –** *Please detail the risks identified, what the family’s views are and the views of the referrer regarding the*

*specific risks to include harm outside of the family (Contextual risk: Person, Place, Premises).* |
|  |
| 1. **Barriers –** *Please detail the barriers i.e. what is stopping the person / parent / child achieving what matters to them.*
 |
|  |
| **5(f) Are you aware of any dangers associated with home visits?** (*e.g. dangerous dogs, violent persons, syringes)* |
|  |

**For concerns of allegations of professional abuse**

|  |  |
| --- | --- |
| **Section 6**  | **About the person(s) responsible for the alleged abuse** |
| **Name:** |  | **Address:** |  |
| **Tel. No.**  |  | **Date of Birth:** |  | **Age:** |  |
| **Are there any children or vulnerable adults in the household?** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Employment Status:** |  |
| **Employing Agencies. List all known.** |  | **Role:** |  |
| **Employer Contact Details** | **Employer** **Address:** |  | **Contact Name:** |  | **Tel. No:** |  |
| **Secondary or voluntary employment Address:** |  | **Contact Name:** |  | **Tel. No:** |  |
| **Does the alleged person of concern have any contact with children/ adults in any employment role?** | **Child** | Yes [ ]  | No [ ]  | N/K [ ]  |
| **Adult** | Yes [ ]  | No [ ]  | N/K [ ]  |
| **Is alleged person of concern an adult at risk?****If yes, please submit a separate referral** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Is the alleged person of concern aware of the referral?** | Yes [ ]  | No [ ]  | Don’t know [ ]  |
| **If there is more than one alleged person in this section, copy and repeat for any other persons** |

|  |  |
| --- | --- |
| **Section 7**  | **Was the incident witnessed?** |
|  |  |
| **WITNESS 1** |
| **Name:** |  | **Address:** |  |
| **Tel. No.**  |  |
| **Relationship to victim:** | Paid Employee [ ]  | Volunteer/ Unpaid employee [ ]  | Relative/ Friend [ ]   | Other ServiceUser [ ]  | Other [ ]  |
| **Is witness a child?** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Is witness aware of referral?** | Yes [ ]  | No [ ]  | Don’t know [ ]  |

|  |
| --- |
| **WITNESS 2** |
| **Name:** |  | **Address:** |  |
| **Tel. No.**  |  |
| **Relationship to victim:** | Paid Employee [ ]  | Volunteer/ Unpaid employee [ ]  | Relative/ Friend [ ]  | Other ServiceUser [ ]  | Other[ ]  |
| **Is witness a child?** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Is witness aware of referral?** | Yes [ ]  | No [ ]  | Don’t know [ ]  |

|  |  |
| --- | --- |
| **For Neath Port Talbot Referrals****please return completed form to:****Adults and Children’s Single Point of Contact**Tel: 01639 686802Email: spoc@npt.gov.uk | **For Swansea Information, Advice and Assistance Team, please return completed form to:** Access.information@swansea.gov.uk MynediadiWybodaeth@abertawe.gov.uk Social services Child and Family IAACity and County of SwanseaPO Box 686SwanseaSA1 3SN or via the use of Egress If you have difficulties using any of these means please contact the team on 01792 635700 to discuss further |
| **For all referrals from a Health Professional, please send a copy to** SBU.Safeguarding@wales.nhs.uk  |

**P*referred option for non-urgent professional referrals is email***