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|  | Multi Agency Safeguarding Hub (MASH) e-form |

MASH Referral Form

# Referral Guidelines

1. Notes for use: If you are completing form electronically, text boxes will expand to fit your text. Where check boxes appear, click to insert an ‘X’ in those that apply
2. This form should be completed by practitioners wishing to refer an infant, child or young person
3. ***If you have concerns that an infant, child or young person may be or is at risk of significant harm or has been harmed or abused then you must make immediate telephone contact with the MASH Team, and then confirm your referral by submitting this e-form within 48 hours***
4. Contact details for the MASH can be found at the end of this form

# Identifying Details

*Record details of unborn baby, infant, child or young person being referred. If unborn, state name as ‘unborn baby’ and mother’s name, e.g. unborn baby of Ann Smith.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Given Name(s): | |  | Family Name: |  |
| Address: | |  | Gender: |  |
| Postcode: |  | | DOB or EDD: |  |
| Contact tel. no. |  | | Unique ref. no. |  |
| AKA/Previous names: |  | | Version no. |  |

# Ethnicity

*Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong. Please tick the appropriate box*

**White**

White British  White Irish  Traveler of Irish Heritage  Gypsy/Roma  Any other White background

**Mixed/multiple ethnic groups**

White & Black Caribbean  White & Black African  White & Asian  Any other Mixed background

**Asian/Asian British**

Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background

**Black/ African/ Caribbean/ Black British**

African  Caribbean  Any other Black background

**Not known**

|  |  |  |
| --- | --- | --- |
| If other, please specify: | |  |
| Immigration status: | |  |
| Child’s first language: |  | |
| Parent’s first language: |  | |

|  |
| --- |
| Is an interpreter required for parent? Yes  No  Is the child or young person disabled? Yes  No |

|  |  |
| --- | --- |
| If ‘yes’ give details: |  |
| Details of any specific requirements (for child and/or their parent) e.g. signing or access needs etc. |  |

# Reason for Referral

Reason for referral: Click or tap here to enter text.

# Current family and home situation

*Example: family structure including siblings (with date of birth), other significant adults etc; who lives with child and who does not live with child*

Current family and home situation:

# Conclusions

*What are your conclusions?*

What is working well?

What are you worried about?

What needs to change?

# Danger Statement

On a scale of 1 – 10, how likely is this to happen? (1 being least likely, 10 being most likely):

# For a child over 10 years please complete

Sexual Health and Behaviour? Click or tap here to enter text.

Absent from school or repeatedly running away? Click or tap here to enter text.

Familial absent and/or problems at home? Click or tap here to enter text.

Emotional and physical conditions? Click or tap here to enter text.

Gangs, older age groups and involvement in crime? Click or tap here to enter text.

Use of technology and sexual bullying? Click or tap here to enter text.

Alcohol and drug misuse? Click or tap here to enter text.

Receipt of unexplained gifts or money? Click or tap here to enter text.

Distrust of authority figures? Click or tap here to enter text.

# Details of parents / carers

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Contact number: |  |
| Address: |  | Relationship: | father |
| Postcode: |  | DOB: |  |

Parental responsibility? Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Contact number: |  |
| Address: |  | Relationship: | mother |
| Postcode: |  | DOB: |  |

Parental responsibility? Yes  No

# Detail of person(s) making referral

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Teresa McMeakin | Contact number: | 0208883 34 12 |
| Address: | Grand Ave | Role: | DSL + Inclusion manager |
| Postcode: | N10 3BP | Organisation: | Tetherdown Primary school |

|  |  |
| --- | --- |
| Name of lead professional (where applicable) |  |
| Lead professional’s number |  |
| Lead professional’s email address |  |

# Services working with infant, child or young person

**GP**

|  |  |  |  |
| --- | --- | --- | --- |
| Details: | No detail of GP at school | Contact number: |  |

**Early years/education/FE training provision**

|  |  |  |  |
| --- | --- | --- | --- |
| Details: |  | Contact number: |  |

**Other services**

|  |  |  |  |
| --- | --- | --- | --- |
| Details: |  | Contact number: |  |

**Child or young person’s comment on the referral and current circumstances: He does not want the school to refer him.**

**Parent and carer’s comment on the referral and current circumstances:** Click or tap here to enter text.

# Consent for Information Sharing

Is the parent/carer/young person aware that you are making this referral? Yes  No

Does the parent/carer/young person consent to information sharing with the Children and Young People’s Service and its partner agencies? Yes  No

If the parent/carer is not aware, please advise them that a referral has been made, except where to do so would place a child or young person at increased risk of significant harm, or place an adult at risk of serious harm.

|  |  |
| --- | --- |
| Signature: |  |
| Name: |  |
| Date: |  |

**Where to send this form**

Please send your completed form to the MASH Team (contact details below). **If you have any concerns that an infant, child or young person may be or is at risk of significant harm or has been harmed or abused then you must make immediate telephone contact with the MASH Team, and then confirm your referral by submitting this e-form within 48 hours.**

**MASH Team**

Address: 3rd Floor, River Park House, 225 High Road, London N22 8HQ

Tel: 020 8489 4470 – office hours (Monday to Thursday 8:45 to 5pm; Friday 8:45 to 4:45pm

020 8348 3148 – out of office hours (including weekends)

Secure email: [mashreferral@haringey.gov.uk](mailto:mashreferral@haringey.gov.uk)