



Potton Services

1 Cresswell Park
Blackheath
London, SE3 9RD
enquiries@potton-kare-services.co.uk
Telephone: +44 (0) 208 090 3054

Potton Services Referral

Please complete all sections of this form

All Children/Young Persons Details Referred:

Name(s) of Children/YP being Referred:	Swift Number(s)	Date of Birth(s)	Gender M/F

Usual or home address of Child/YP:

Postcode:

Temporary or Placement Address: (e.g. staying with relative or friend or Foster Carer)

Name of Foster Carer:

Postcode:

Current Contact Numbers:

Name:	Relationship/Child or YP	Mobile No/Home No:

Invoice to:-

Name:

Department:

Email:

Tel No:

Potton Services Ltd. Registered in England and Wales No: 10846128
Registered Address: 1 Cresswell Park, London SE3 9RD





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Childs/Young Person's Religion : Please state

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Child/Young Person's Ethnicity :

The categories below are defined by the Department of Health. In addition to helping us to consider the particular needs of the child/young person being referred, this information, will allow better planning of the services

Please enter X where appropriate:

White

Black or Black British

<input type="checkbox"/> British	<input type="checkbox"/> African
<input type="checkbox"/> Irish	<input type="checkbox"/> Caribbean
<input type="checkbox"/> Other White (please state below)	<input type="checkbox"/> Other Black (please state below)
<input type="checkbox"/>	<input type="checkbox"/>

Asian or Asian British

Mixed

<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> White and Black Caribbean
<input type="checkbox"/> Indian	<input type="checkbox"/> White and Black African
<input type="checkbox"/> Pakistani	<input type="checkbox"/> White and Asian
<input type="checkbox"/> Other Asian (please state below)	<input type="checkbox"/> Other Mixed (please state below)
<input type="checkbox"/>	<input type="checkbox"/>

Chinese or other ethnic group

Traveller,Roma or Gypsy

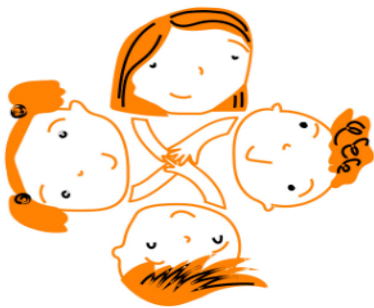
<input type="checkbox"/> Chinese	<input type="checkbox"/> Traveller
<input type="checkbox"/> Other ethnic group	<input type="checkbox"/> Roma
<input type="checkbox"/> (please state below)	<input type="checkbox"/> Gypsy
<input type="checkbox"/>	<input type="checkbox"/>

Communication :

Child's First Language :

Parent(s)/Carer(s) First Language :

Any special communication needs? **Yes** **No**



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Registered/Statutory Status: Please give details of name of child/young person, dates, category (if known).		Date:	Information:
Any child in family is/has been on the child protection plan?	Y <input type="checkbox"/> N <input type="checkbox"/>		<u>Category: Neglect</u> All children are subject to a CP plan.
Any child or other family member is/has been looked after by a local authority?	Y <input type="checkbox"/> N <input type="checkbox"/>		<u>Order:</u>
Any child in the family has a disability?	Y <input type="checkbox"/> N <input type="checkbox"/>		<u>Specify</u>
Any child in the family a Child in Care?	Y <input type="checkbox"/> N <input type="checkbox"/>		<u>Order:</u>
Any child in the family a Child in Need?	Y <input type="checkbox"/> N <input type="checkbox"/>		
Any Current criminal proceedings?	Y <input type="checkbox"/> N <input type="checkbox"/>		<u>Name:</u>

Risk and Vulnerability Issues

Is it safe to visit the young person/Family at home?

Has the young person / family displayed any of the following behaviours?

<input type="checkbox"/>	Verbally abusive behaviour	<input type="checkbox"/>	Unpredictability due to substance misuse
<input type="checkbox"/>	Violent offences / behaviour	<input type="checkbox"/>	Unpredictability due to mental health issues
<input type="checkbox"/>	Verbal abuse / threats towards agency staff	<input type="checkbox"/>	Sexual offences / sexually inappropriate behaviour
<input type="checkbox"/>	Physical violence towards agency staff	<input type="checkbox"/>	Self-harm / attempted suicide
<input type="checkbox"/>	Racist / homophobic abuse or other hate crime	<input type="checkbox"/>	Other

Please Provide Details:

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Please provide details of who to contact for Out of Hours reporting:

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Main Carers & Other Siblings at the home address:

Surname	Forename	Tel No.	Date of Birth	Relationship	Parental Resp
					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Agencies involved with the child :

Agency	Name & contact details	Nature of contact with young person

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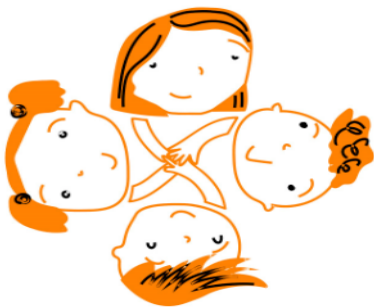
History of case & current situation:

What are the issues that need addressing to stop accommodation into care:

What previous resources have the family accessed and how successful were these:

**Please indicate what level of support you would envisage the family will need:
i.e. Times & No of days and the frequency you would like reports submitted.**

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Please indicate how often review meetings of plan will be held:

Awareness of Referral:

Is the parent/carer aware of the referral	Yes <input type="checkbox"/>
	No <input type="checkbox"/>
Is the child/young person aware	Yes <input type="checkbox"/>
	No <input type="checkbox"/>

Referred by :

Social worker:

Name:
Email:
Tel:
Date:

Authorizing Manager:

Name:
Email:
Tel:
Date:

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