**CHANGING FACES**

*OFFICE USE ONLY* – **FAMILY NUMBER**

**PARENT SUPPORT**

**REFERRAL FORM**

*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.*

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| ***We also require a copy of the most up to date CSE Risk Assessment for the CYP – if you cannot provide this, call FACES*** |
| 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 |

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| **Information about the parents/carers involved with the child(ren)** | | | | | | |
| **Name of Family:** | | | | | | |
| **Address (inc post code):** | | **All telephone numbers:** | | | | |
| **Relationship to Child(ren)** | **Name,**  **DOB** | | **Main Carer**  **√** | **Parental**  **Responsibility √** | | **Resident in family home √** |
| **Mother/Partner**  **DOB/**  **Ethnic Origin** |  | |  |  | |  |
| **Father/Partner**  **DOB/**  **Ethnic Origin** |  | |  |  | |  |
| **Other Main Carer**  **DOB/**  **Ethnic Origin** |  | |  |  | |  |
| **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:** | | | | | | |
| **Have you explained to the family what FACES role will be and how you anticipate us supporting them and that referral into this service is voluntary?** | | | | | | |
| **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?** | | | | | | |
| **If CAMHS involved can we contact them with a view to establishing the appropriateness of parallel support at this time?** | | | | | | |
| **Are there any Health and Safety issues we need to consider?** | | | | | | |
| **Please indicate family need below (overarching is the need for support to keep young person safe and free from risk of CSE, CCE and/or SV)** | | | | | **Tick if applicable** | |
| Confidence in Identifying Warning Signs around exploitation (CSE, CCE, SV)  Why/how do you want FACES to support? | | | | |  | |
| Recognising the Warning Signs of Exploitation  Why/how do you want FACES to support? | | | | |  | |
| Understanding Dangers of Exploitation  Why/how do you want FACES to support? | | | | |  | |
| Parental Ability to keep CYP safe from exploitation  Why/how do you want FACES to support? | | | | |  | |
| Support to establish effective network of support  Why/how do you want FACES to support? | | | | |  | |
| Improved communication in the home  Why/how do you want FACES to support? | | | | |  | |
| Parental ability to confidently implement boundaries around this issue  Why/how do you want FACES to support? | | | | |  | |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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 | | | | | | | |
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| **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](mailto:office@facesbedford.org) (Tel: 01234 270601)

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