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| **WALSALL SAFEGUARDING CHILDREN BOARD****Multi-Agency Referral** **Form (MARF)** |  |
| **For use when making referrals in to the** **Multi Agency Safeguarding Hub (MASH)** |
| This form should be used to make a referral to Walsall Children’s Services.Please ensure that **ALL FIELDS ON THIS PAGE ARE COMPLETED IN FULL**Where you believe there is immediate risk of significant harm, please contact the police.For urgent safeguarding concerns please make the referral by telephone to **0300 555 2866** (**out of hours – 0300 555 2922**) and submit the MARF within 24 hoursThe completed form should then be sent by email to MASH@walsall.gcsx.gov.uk **MARF’s WITH INSUFFICIENT INFORMATION WILL BE RETURNED** |

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| **REFERRAL DATE**  |  | **TIME** |  |

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| **Who have you spoken to about this referral?** Provide, name, date and time and advice or plan decided*Eg. MASH, Early help hub, line manager, designated safeguarding lead (DSL)* |  |
| **SIGNATURES** | **Person Making Referral** | **Child Protection Lead/ Line Manager** |
| ***Print Name*** |  |  |
| ***Signature*** |  |  |

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| **CONSENT** |
| **Are parents/carers aware of the referral to the MASH?****(Please select Yes or No)** | **Yes** |  | **No** |  | **Written or Verbal**(Delete as appropriate) |
| **Has consent been obtained from the parent/carer to share information?****(Please select Yes or No)** | **Yes** |  | **No** |  |  |
| **If consent has NOT been obtained, please record the reason/s for this** |  |
| Do you consider that the child/young person is at IMMEDIATE RISK OF HARM? |
| YES |  | NO |  |

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| **Unborn / Child / Young Person** |
| **Child Forename** | **Child Surname** | **Gender** | **Date of Birth/EDD** | **NHS Number** |
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| **if unborn baby - Hospital where booked**  |  |
| **Address: Include all addresses where the child/ren reside** | **Telephone Number:** |
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| **Ethnic Origin** |  |
| **1st Language** |  |
| **Religion/ Belief** |  |
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| **Parent /Carer Details** |
|  | **Person 1** | **Person 2** |
| **Forename:** |  |  |
| **Surname:** |  |  |
| **DOB:** |  |  |
| **Relationship:** |  |  |
| **Address:** |  |  |
| **Telephone Number:** |  |  |
| **First Language:** |  |  |
| **Is an Interpreter / Signer required?** |  |  |
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| **Other Household Members**  |
| **Forenames** | **Surname** | **DOB** | **Relationship** | **Also referred?** **Enter Yes or No** |
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| **Are you aware of any of the following concerns? (tick as appropriate):** |
| **Domestic Abuse** |  | **Substance Misuse** |  | **Disabilities / Learning Difficulties** |  | **Neglect**  |  |
| **Mental Illness** |  | **CSE** |  | **Young Carer** |  | **Private Fostering** |  |

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| **What are the presenting risks and impact to the child or young person?****What does this mean to the child or young person now?**  |
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| **Reason for Referral** **Please use the following headings to structure your referral and identify how a referral to MASH will address the issues you have highlighted and lead to an improvement in the situation** |
| **Presenting concerns***(please describe the incident or circumstances that have led to a referral being made)* |  |
| **Development of child *–*** *health, behaviour, family relationships etc.* |  |
| **Safety and protection, emotional warmth, stimulation** |  |
| **Family and environmental *– functioning and well-being /Other factors*** *(e.g. issues related to: alcohol misuse, drug misuse, domestic violence, mental health problems, learning difficulties, offending behaviour / imprisonments and offences again children, any significant history)* |  |
| **Please outline any services that have been provided to address any previous concerns prior to this referral.** |  |
| **Voice of the Child***(does the child feel safe, what have they said or done, behaviour around family etc.)* |  |
| **Has an Early Help Assessment been completed?** | **Yes** |  | **Lead worker details** |  |
| ***If so, provide copy*** | **No** |  | **Why not?** |  |

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| **Which threshold level do you feel this referral meets?** |
| **If Level 1 (Universal) or Level 2 (Single Agency Early Help) do not submit this MARF**  | **Level 3**Multiagency Early Help |  | **Level 4**Complex Significant Needs |  |

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| **Details of referrer** |
| **Name** |  |
| **Designation** |  |
| **Organisation** |  |
| **Address** |  |
| **Post Code** |  |
| **Email address** |  |
| **Tel No** |  |
| **Are you aware of previous referrals being made regarding this child/family?** |  Yes / No (delete as appropriate) |  If Yes, what were the issues or concerns? |
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| **Are you aware of any other agencies involved (e.g. GP, Health Visitor, School Nurse, CAMHS, Youth Justice Service)** |
| **Name** | **Designation** | **Address** | **Tel** |
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| **Useful Reading** |
|   Threshold document <http://wlscb.org.uk/professionals-volunteers/thresholds/>  Early Help web page <http://www.mywalsall.org/walsallearlyhelp/>  Step Up/ Step Down Protocol <http://wlscb.org.uk/guidance/> (Chapter 3.25)  CSE Screening tools <http://wlscb.org.uk/parents-carers/child-sexual-exploitation/>  Young Carers Screening tool <http://www.mywalsall.org/walsallearlyhelp/providers-youngcarers/> |

