



Trafford Borough Council is committed to developing a service which benefits all Children in Need.

The Child in Need/Child Protection Procedures encapsulate this ethic by outlining our multi-agency threshold criteria for services.

The assessment framework is the assessment tool adopted by all our ACPC partner agencies and the Children & Young People's Service to identify children and family needs.

The Multi-Agency Assessment and Referral Form ensures that children and families have had their needs assessed to an appropriate level and that information has been gathered using the assessment framework tool.

The Child in Need/Child Protection Procedures, as per Lord Laming's recommendations, require that all referrals to the Children & Young People's Service are followed up in writing within 48 hours. We expect that all referrals have been discussed with the family and their agreement to the referral being made gained. Please note that this also applies to child protection concerns except in cases where the referrer is of the opinion that informing carers/parents would put themselves and/or the child at further risk and in cases of suspected sexual abuse.

Please note that referral forms include a section for parent/carers' signatures giving consent to the referral being made and for the Children & Young People's Service to contact other agencies in the process of their assessment.

Once faxed or emailed, the completed Assessment and Referral Form should be posted to:

Multi Agency Referral & Assessment Team
3rd Floor Extension
Trafford Town Hall
Talbot Road
Old Trafford
M32 0TH



Trafford CYPS brings together council and health services to improve outcomes for children, young people, their families and schools.

MULTI-AGENCY ASSESSMENT AND REFERRAL FORM

This joint-agency assessment and referral form should be used when an agency considers that a child has needs which cannot be met solely by that agency, and where co-ordinated intervention is required to promote, safeguard or protect the welfare of the child/children concerned. Please forward the completed form within 48 hours of telephone referral.

Completed by Date

Designation and Agency Tel No

Address of Referrer

DETAILS OF CHILD/CHILDREN

Family Surname(s) (or alias)

Names of child(ren)	M/F	DOB	Nursery/School	Ethnicity	Religion
.....
.....
.....
.....

Address Telephone number:

Parent's first language Is an interpreter or signer required?.....

GP Name/Address NHS No

FAMILY DETAILS

Parents names (forename and family name/surname) DOB

Mother DOB

Father DOB

Other significant adults in the household DOB

..... DOB

..... DOB

Family's Previous Address

If immediate protective action is required, a child protection referral must be made by telephone/visit to the local Children & Young People's Service office. Please note that a child protection referral must not be delayed. This joint-agency form must be completed and forwarded to Children & Young People's Service following the telephone referral within 48 hours.

Information on statutory status:		Please give details:
Child/young person or other child(ren)/young person(s) in family is/has been on a disability register:	Yes/No
Child/young person has Statement of Educational Need:	Yes/No
Child/young person or other child(ren)/young person(s) in family is/has been on a child protection register:	Yes/No	Category:
Child/young person or other family member(s) has/have been looked after by a local authority:	Yes/No

Reason for referral to Children & Young People's Service *(please indicate if previous referrals have been made and attach any relevant information)*

DETAILS OF OTHER AGENCIES INVOLVED WITH THE FAMILY/CHILD(REN)			
Agency	Names	Address and Tel No	Current Involvement

Summary of Main Areas of Concern:
(to be completed by professionals who have access to the following information:

Child's Health and Development:

Parenting Skills:

Family and Environmental Factors:

Please outline the work undertaken by your agency to assist this child/family: *(please also include any contact which has been made with other agencies in respect of this referral and provide details of any joint work)*

ADDITIONAL INFORMATION

What are the child's views about this referral?

Does the child consent to the sharing of information between agencies?

Yes

No

What are the parents' views about your concerns and this referral?

Please detail any special needs or circumstances of any family member which may affect this referral or communication and understanding between the family and professional agencies

I agree for this referral to be made to the Children & Young People's Service and understand that they will contact other appropriate agencies

Signed(Parent/Carer)

Date

Signed

Designation

Forwarded to:

Copy to:

Date:

PLEASE RETURN THIS FORM TO:
Multi Agency Referral & Assessment Team
Trafford Town Hall
Talbot Road
Old Trafford
M32 0TH

Tel: General Referral Line 0161 912 5125
Child Protection Line 0161 912 5124

Fax: 0161 912 5056

Email: MARAT@trafford.gov.uk

RESPONSE OF CHILDREN & YOUNG PEOPLE'S SERVICE TEAM

Acknowledgement to be returned to the referring agency within seven working days

Name of child:

Address:

..... Post code

THE NEEDS OF THIS CHILD HAVE BEEN CONSIDERED AND THE FOLLOWING ACTION IS TO BE TAKEN:

ACTION	COMMENTS <i>(please give details)</i>
No further action by Children & Young People's Service	
Provision of information and advice	
Referral out to other agencies	
Initial Assessment	
Provision of services under Section 17	
Core or specialist assessment required	
Service Provision Agreement meeting under Section 17	
Consideration under Child Protection Procedures under Section 47	
Other comments	

Copy to (referring agency): **Date:**

Signed: **Tel No:**

Name (print): **Designation:**