UCLH Safeguarding Referral Form

*The Children’s* ***FGM*** *clinic is run jointly with consultant gynaecologist Professor Sarah Creighton and is monthly; however urgent appointments may be possible.*

***Please complete the form ensuring you have answered the questions with an asterisk (\*) and email back to*** **UCLH.PaediatricSafeguarding@nhs.net****. If you have any problems u can contact 0203 447 5241.**

**FGM - physical examination required consultation at UCLH requested ![C:\Users\lwillia7\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\HQ04AUYW\basic-square-outline[1].jpg]()**

**FGM- second opinion on a recorded examination on a DVD (DVD will be sent to UCLH) ![C:\Users\lwillia7\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\HQ04AUYW\basic-square-outline[1].jpg]()**

|  |  |  |  |
| --- | --- | --- | --- |
| **\*Referrer’s name, Job Title & Contact Number** |  | **\*Date of Referral** |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  **CHILD** |  | **Gender** | Male [ ]  Female [ ]  |
| **Forename**  |  |  |  |  |  | **Surname** |  |
| **Date of Birth** |  |  |  | **NHS No** |  |  |  |
| **Address\*** |  |  |  |  |  |  |
|  |  |  |  | **Temporary or Permanent** |  | Temporary [ ] Permanent [ ]  |  |
|  |
| **Post Code\*** |  |  |  |  |  |
| **Telephone No\*:** |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |
| **Name of mother** |  | **Address:** | **Parental responsibility** [ ]  **YES** [ ]  **NO** |  |
| **Name of father** |  |

|  |  |
| --- | --- |
|  **Address:** | **Parental responsibility** [ ]  **YES** [ ]  **NO** |

 | **Parental responsibility** [ ]  **YES** [ ]  **NO** |  |
| **Can letter be sent to both parents**  |  | [ ]  **YES** [ ]  **NO** |  |  |
|  |  |  |  |  |  |  |  |
| **Name of parent(s) accompanying child** |  |  | *Please circle*[ ]  **Mother** [ ]  **Father** |  |
|  |  |  |  |  |  |  |  |
| **If with foster carer, please add** **name** |  |  |
|  |  |  |  |
| **\*GP Name and Address\*** |  | **\*School name and address** |  |
|  |  |  |  |
| **\*Allocated Social Worker Name & Address and****phone number** |  | **\*Name of social worker attending the appointment** |  |
|  |
|  |  |  |  |
| **Are Safeguarding Team (Police) Involved** | Yes [ ]  No [ ]  | **Officer In Charge (Police) Team Details**(Name, Job role, Address, Email & Contact telephone number) |   |
|  |  |  |  |
| **Has child had ABE interview (Police)** | Yes [ ]  No [ ] NA [ ]  | Family Previously Known to Social Care? | Yes [ ]  No [ ] **If Yes**, under what category?CPP [ ]  CIN [ ]  |
|  |  |  |  |
| **Are CAMHS Involved** | Yes [ ]  No [ ]  NA [ ]  | **CAMHS Team Details**(Name, Job role, Address, Email & Contact telephone number) |  |
|  |  |  |  |
| **Reason for referral - summary of allegation,** *please summarise and include reason for this appointment and attach key documents see below* |

**Please attach the following, if available and check (****[x] ) to let us know which you have enclosed \***

[ ]  **Strategy meeting minutes/actions following this referral**

[ ]  **Chronology of Social Care Involvement**

[ ]  **If previously known to social care – last conference report or child in need report**

[ ]  **ABE Interview Report/ notes/summary**

[ ]  **LAC medical report if done**