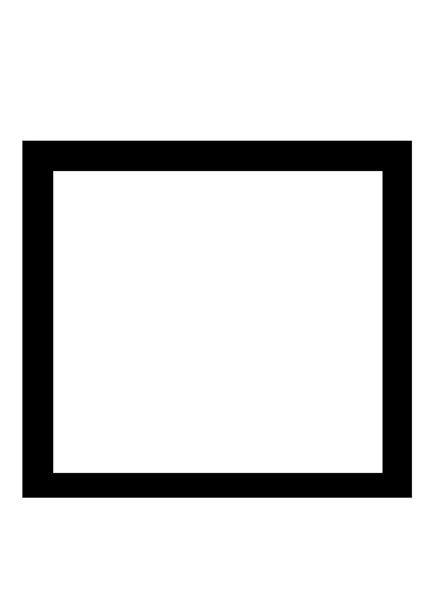
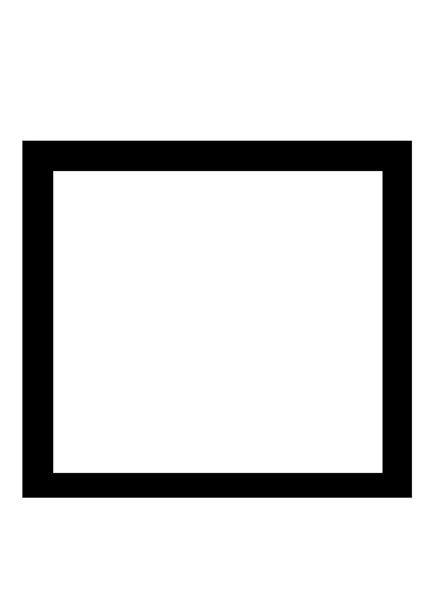
UCLH Safeguarding Referral Form

*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**](mailto:UCLH.PaediatricSafeguarding@nhs.net)**. If you have any problems u can contact 0203 447 5241.**

**FGM - physical examination required consultation at UCLH requested **

**FGM- second opinion on a recorded examination on a DVD (DVD will be sent to UCLH) **

|  |  |  |  |
| --- | --- | --- | --- |
| **\*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 (****) 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**