



## NEL Sunrise Hub Child Sexual Abuse integrated referral form

<b>What Service is being requested (tick all that apply)</b>		* CYP = child young person	
CSA Health Assessment (Royal London Hospital)	<input type="checkbox"/>		
CSA Emotional wellbeing support (TIGER Light)	<input type="checkbox"/>		
Email completed form to <a href="mailto:bartshealth.nelcsahub@nhs.net">bartshealth.nelcsahub@nhs.net</a> (will be seen by Health team and Tiger service)			
<b>(For TIGER only) Please confirm if the young person would prefer virtual sessions or face-to-face sessions?</b>  Check first with the CYP to confirm.	<input type="checkbox"/> <b>Face to Face</b> <input type="checkbox"/> <b>Virtual</b>  All sessions are delivered face to face for children under 10		
<b>Consent (tick all that apply)</b>			
Has the CYP been deemed Gillick Competent* in relation to this referral and has consented?  <small>*term used to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission</small>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  <b>Please ensure Confirmation CYP gave consent to referral if aged 13+</b>		
Confirmation CYP parents gave consent to referral and are in agreement with referral (if CYP not Gillick competent)	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		

### Details of professional making referral

Date of Referral:	Click or tap here to enter text.		
Full Name:	Click or tap here to enter text.		
Department and job title:	Click or tap here to enter text.		
Local Authority/NHS Trust:	Click or tap here to enter text.		
Relationship to CYP:	Click or tap here to enter text.		
Email address:	Click or tap here to enter text.	Contact no:	Click or tap here to enter text.

Line manager's name and contact details: Click or tap here to enter text.	
---	--

**Child /young person (CYP) details**

Full name	Click or tap here to enter text.		
Preferred name if different	Click or tap here to enter text.		
Date of Birth	Click or tap here to enter text.	Age at time of Referral	Click or tap here to enter text.
NHS Number	Click or tap here to enter text.		
GP Practice name:Click or tap here to enter text.	GP contact details:Click or tap here to enter text.		
Gender identity (if known)	Click or tap here to enter text.	Sexual orientation (if known)	Click or tap here to enter text.
Ethnicity	Asian background – any <input type="checkbox"/> White background – any <input type="checkbox"/> Black background – any <input type="checkbox"/> Other background – any <input type="checkbox"/> Mixed background – any <input type="checkbox"/> Not known/not stated <input type="checkbox"/>		
Preferred first language	Click or tap here to enter text.	Interpreter required:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Postal Address and post code	Click or tap here to enter text.		
Email address if available: Click or tap here to enter text.	Safe to email:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Safe contact number	Click or tap here to enter text.		
Safe to leave voice messages:	<input type="checkbox"/> Yes	Safe to leave text messages: Yes/No	<input type="checkbox"/> Yes

	<input type="checkbox"/> No		<input type="checkbox"/> No
Safe contact times (am/pm):	Click or tap here to enter text.		
Does the child have additional needs, such as a disability or difficulties with communication	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details:	Click or tap here to enter text.		
Does the CYP have an EHCP or any suspected learning needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details	Click or tap here to enter text.		

### Parents / persons with parental responsibility details

Full Name	Click or tap here to enter text.		
Relationship to child:	Click or tap here to enter text.		
Preferred language	Click or tap here to enter text.		
Interpreter required	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Full postal Address and post code	Click or tap here to enter text.		
Telephone number	Click or tap here to enter text.	Safe to leave voice messages	<input type="checkbox"/> YES <input type="checkbox"/> NO
Email address	Click or tap here to enter text.	Safe to email	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is it safe to contact this person?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Safe to leave text messages: Yes/No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this person an emergency contact?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

If no, please add emergency contact details	
Best contact times am and pm.	Click or tap here to enter text.
Any other relevant information	Click or tap here to enter text.

### About the referral

Does this referral relate to an allegation of sexual abuse/assault within the last 7 days?	<input type="checkbox"/> YES ( <b>If yes</b> , refer to police/ Havens immediately). <input type="checkbox"/> NO <input type="checkbox"/> Not known.
<b>Summary of sexual abuse allegations/concerns:</b>	
Please include: Who did the CYP make the initial allegation to and how did they tell? What happened? When did it happen? Where did it happen? How old was the young person? Was it an isolated incident?	
Click or tap here to enter text.	
<b>Please outline the current impact of the abuse on the CYP:</b> Include impact of Emotional wellbeing, Behaviour, Relationship with others, Physical and Educational	
Click or tap here to enter text.	
<b>What is the parent/carer response to the sexual abuse/assault allegations? (Do they believe the allegations? Have they responded appropriately?)</b>	Click or tap here to enter text.
What are the desired outcomes and best hopes for this referral?	Click or tap here to enter text.
Please share any relevant information with regards to the family history and functioning: This information provides practitioners with essential background information to consider as part of support and intervention.	
Click or tap here to enter text.	
Please provide any details of the CYP/family strengths and protective factors: This information helps us to plan the best ways to support the CYP	
Click or tap here to enter text.	

### Details of Safeguarding Status

Is the child currently open to children's social care?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>If yes</b> , please confirm status	<input type="checkbox"/> Undergoing Child and Family assessment <input type="checkbox"/> Child In Need (CIN) <input type="checkbox"/> Child protection (CP) Category:	<input type="checkbox"/> Looked after child (LAC) <input type="checkbox"/> Accommodated under S20
Details of Allocated Social Worker: Name, team/department, contact number, email address Click or tap here to enter text.		
Has a strategy discussion taken place regarding this referral?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>If yes</b> , please provide details: Date/time/outcome: Click or tap here to enter text.		
Is the CYP/family in contact with the alleged perpetrator of sexual abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>If yes</b> , please provide details: Click or tap here to enter text.		
Does this young person pose a risk towards others?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>If yes</b> , please provide details: risk towards adults/peers/staff/allegations against professionals etc. Click or tap here to enter text.		
Has there been previous involvement with children's social care? If yes, please provide brief details on previous involvement:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Click or tap here to enter text.		

**Police investigation details (if applicable)**

Investigating Officer in Charge details: Name/rank/contact number/email address Click or tap here to enter text.		CRIS Number: Click or tap here to enter text.	
Details of police Video Recorded Interview (VRI):	<input type="checkbox"/> VRI Completed: Date: <input type="checkbox"/> VRI Pending: Date:	<input type="checkbox"/> CYP Declined <input type="checkbox"/> Awaiting intermediary assessment	
Has the suspect been arrested?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>If yes</b> , please provide status. <b>Please check applicable boxes if known</b>	<input type="checkbox"/> Bail <input type="checkbox"/> remanded <input type="checkbox"/> not known	<input type="checkbox"/> Caution <input type="checkbox"/> Other	<input type="checkbox"/> Youth Conditional Order <input type="checkbox"/> Youth caution
<b>What is the status of police investigation if known</b>	<input type="checkbox"/> Ongoing <input type="checkbox"/> Awaiting CPS decision/court date	<input type="checkbox"/> No further Action (NFA) <input type="checkbox"/> other	

**Details of other professionals involved:**

<b>School:</b> Click or tap here to enter text.	Contact name: Click or tap here to enter text.	Contact Number: Click or tap here to enter text.	Email address: Click or tap here to enter text.
<b>CAMHS:</b> Click or tap here to enter text.	Job title: Click or tap here to enter text.	Contact Number: Click or tap here to enter text.	Email address: Click or tap here to enter text.
<b>Other</b> (i.e Early Help, ISVA, etc.): Click or tap here to enter text.	Job Title: Click or tap here to enter text.	Contact Number: Click or tap here to enter text.	Email address: Click or tap here to enter text.

**Experiential Factors to be taken into consideration.**

Please tick all relevant boxes

Contextual Safeguarding Factors	<input type="checkbox"/> Entering vehicles with unknown adults <input type="checkbox"/> Exclusion or poor attendance <input type="checkbox"/> Location areas of concern <input type="checkbox"/> Missing episodes	<input type="checkbox"/> Possibility of being trafficked. <input type="checkbox"/> Unexplained gifts/possessions <input type="checkbox"/> Unexplained sexual relationships with older persons
Familial factors	<input type="checkbox"/> Bereavement or significant loss <input type="checkbox"/> Disrupted family life. <input type="checkbox"/> Parental mental health issues <input type="checkbox"/> Parental Substance misuse	<input type="checkbox"/> Placement breakdown (current) <input type="checkbox"/> Placement breakdown (multiple) <input type="checkbox"/> Siblings/family involved in gangs/offending. <input type="checkbox"/> Young carer
Health factors	<input type="checkbox"/> Eating disorders <input type="checkbox"/> Poor emotional health <input type="checkbox"/> Self - harm	<input type="checkbox"/> Sexual health concerns <input type="checkbox"/> Substance misuse
Peer factors	<input type="checkbox"/> Inappropriate peer group	<input type="checkbox"/> Links to other victims of CSE/gangs
Personal factors	<input type="checkbox"/> Bereavement or significant loss <input type="checkbox"/> Disclosure of Sexual Exploitation <input type="checkbox"/> Disrupted sleep/nightmares. <input type="checkbox"/> Exposure to domestic abuse or violence <input type="checkbox"/> Exposure to pornography <input type="checkbox"/> Homeless <input type="checkbox"/> Inappropriate sexualised behaviours	<input type="checkbox"/> Inappropriate use of internet <input type="checkbox"/> Living in residential care <input type="checkbox"/> Secretive behaviour incl. internet use <input type="checkbox"/> Victim of crime <input type="checkbox"/> Volatile behaviour <input type="checkbox"/> Inappropriate sexualised behaviours
<p>Please add specific information with regards to the above ticked boxes</p> <p>Click or tap here to enter text.</p>		

**Supporting documentation:** Please send as many as possible of the following documentation with the referral request. Please ensure you mark boxes for relevant documents sent as attachments with this form.

<p>We will not be able to progress the referral within agreed timeframes without sufficient information.</p> <p>Please ensure you mark boxes for relevant documents sent as attachments with this form</p>	<p><input type="checkbox"/> Relevant strategy</p> <p><input type="checkbox"/> Health / psychiatric reports</p> <p><input type="checkbox"/> Case conference minutes</p> <p><input type="checkbox"/> Genogram / chronology</p>	<p><input type="checkbox"/> Pre-sentence report</p> <p><input type="checkbox"/> Victim’s witness statement</p> <p><input type="checkbox"/> SEN statement / copy of EHCP</p> <p><input type="checkbox"/> Other (please specify)</p>
--	--	--

**Thank you for completing this form, if you have any questions about this form or the services, please make contact using the details in the foot note.**