* **Please complete this form on line, attach any relevant documents and send by secure email.**

**Appendix 2**

* **The paediatric team should be contacted by phone to ensure the referral has been received.**
* **The medical assessment will only take place by prior appointment with the on-call paediatrician.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Time | | | | | Referring Social Worker | | |  | | |
| Reason for referral | Physical abuse  Neglect  Other (please state): | | | | | | | | | | |
| Referrer’s base |  | | | | | Contact Details:  Mobile number  Office number | | |  | | |
| Name of child: M  F |  | | | | | Date of Birth | | |  | | |
| Address |  | | | | | GP Name and address | | |  | | |
| NHS No (if known) |  | | | | | Ethnicity | | |  | | |
| School / Nursery |  | | | | | Interpreter arranged  Yes  Not required  First language: | | | | | |
| Name of allocated Social Worker (if not the referrer) |  | | | | | Contact Details:  Mobile number  Office number | | | |  | |
| **Details of incident leading to referral and known injuries:** | | | | | | | | | | | |
| Strategy Meeting | | Date:  Time: | | | | Minutes attached Yes  No  **(Please forward as soon as possible)** | | | | | |
| Previously known to Yes  Social Care No | | Current Yes  CP Plan No | | | | Current Yes  CIN Plan No | | | Previous Yes  CP medical No | | |
| Police Involvement Yes  No | | Name of Officer & Contact details | | | |  | | | | | |
| Child interviewed by social worker | | Yes  No | | | | Child interviewed by Police | | | Yes  No  N/A | | |
| Current location of child/children | |  | | | | | | | | | |
| Have arrangements been made for safe Yes  accommodation for the child/children? No  **(This should not be dependent on the outcome of the medical assessment)** | | | | | | Details: | | | | | |
| Who holds Parental Responsibility?**\*** | |  | | | | | | | | | |
| Who has given verbal consent for CP medical?\* | |  | | | | Who will attend to provide **informed written consent**?\* | | | | |  |
| Who will be attending to provide the medical history? | |  | | | | Who else will be attending? | | | | |  |
| Father’s Name: | | | | DOB: | | | Contact Details: | | | | |
| Mother Name: | | | | DOB: | | | Contact Details: | | | | |
| Carer’s Name: | | | | Contact Details: | | | | | | | |
| Names of siblings | | | DOB of siblings | | | | | Child protection medical required? | | | |
|  | | |  | | | | |  | | | |
| Other significant family or household members:  Any relevant family medical and social history and include the composition of the family, if relevant: | | | | | | | | | | | |
| Additional information: | | | | | | | | | | | |
| Appointment date and time (if agreed with Social Worker during strategy discussion) | | | | | Date :       Time : | | | | | | |

**Office Use Only:**

|  |  |
| --- | --- |
| Referral discussed with: Dr | Accepted:  Rejected:  Reason: |
| Confirmed appointment date:       Time:  Venue: | Examining Dr(s): |
| CP Admin Name: | Date :      Time: |

**\*CONSENT**

* *Child Protection examinations will* ***only be carried out with written consent in line with guidelines and LSCB protocol***
* *If the parent/person with PR is not able to attend,* ***the Social Worker must obtain written consent*** *and/or ensure that a person with parental responsibility is available by phone to give verbal consent*
* *Children 16 and above may consent for themselves however it is best practice to also obtain parental consent*
* *Children 13-16 may consent if deemed competent by the examining paediatrician although parental consent should always sought.*
* *Consent may be obtained through the Court if applicable.*

***- Appointment times in the community clinics (Luton & Bedford) will be at 14:00 and 15:30 Monday to Friday (unless an alternative time has been offered by the paediatrician)- by prior arrangement only.***

***- CP medicals required in hospital must be arranged by consultation with the on-call paediatrician.***

Referral form to be sent to:

**Appendix 2**

**Referral to Community Paediatric Services**

**Physical abuse > 2years of age**

**Children of all ages where there are concerns of neglect (unless hospital treatment is required)**

**South Bedfordshire**

Edwin Lobo Centre, Redgrave Gardens, Luton, Beds, LU3 3QN

Tel: 01582 345945

E-mail: [ccs-tr.elccpmedicals@nhs.net](mailto:ccs-tr.elccpmedicals@nhs.net)

**North Bedfordshire**

1. Child Development Centre, Hill Rise, Kempston, Bedford, MK42 7EB
2. Union Street Clinic, Union Street, Bedford. MK40 2SF

E-mail: [ccs.beds.childrens.cp.meds@nhs.net](mailto:ccs.beds.childrens.cp.meds@nhs.net)

Tel: 0300 790 6490

**Referral to Hospital Paediatrics**

**Physical abuse of children <2 years of age**

**ALL Out of Hours referrals (normal weekdays after 17:00 ; weekends and public/bank holidays.**

**South Bedfordshire**

Luton & Dunstable Hospital, Lewsey Road, Luton, Beds, LU4 ODZ

Tel: 01582 497023 / 718298

*E-mail :* [ldh-tr.luton.cpdmeds@nhs.net](mailto:ldh-tr.luton.cpdmeds@nhs.net)

**North Bedfordshire**

Bedford Hospital, Kempston Road, Bedford, MK42 9DJ

Tel: 01234 355122 *and ask for the on-call Consultant Paediatrician who will provide a secure email address as this will be dependence upon who is on duty.*

**Important notice:**

* **All concerns involving sexual abuse please discuss directly with SARC without delay at the Emerald Centre on 0330 223 0099**
* **Children should not be taken to the hospital Emergency Unit or Community Paediatric setting without prior arrangements unless the child requires immediate medical attention.**