**CFCS Referral Consultation Request Form (CSC Assessment Teams)**

**Families First/Social Care CFCS Team** (updated 13 5 15)

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| *Before you proceed, please confirm that (the request will not be accepted without this information):*  ☐ The case is not currently open to CFCS. If the case is open to CFCS, please contact the allocated clinician. If unsure, please ring the reception 020 7055 8400 to check.  ☐ There are no urgent mental health risk issues (If there is urgent mental health risk, please ring CFCS on 020 7055 8400 and speak to a CFCS duty clinician to make an urgent referral). | |
| Date:Click here to enter text.  *Your details*  Name: Click here to enter text.  Tel: Click here to enter text.  Mobile: Click here to enter text.  Email: Click here to enter text.  Role: ☐ Social Worker ☐ Advanced Practitioner  ☐ Practice Manager ☐Team Manager  ☐Other Click here to enter text.  Team: Assessment Team Click here to enter text.  Other Click here to enter text.  Manager: Click here to enter text. | *Case details (include all siblings)*  Child/YP Click here to enter text.  DoB: Click here to enter text.  Child/YP Click here to enter text.  DoB: Click here to enter text.  Child/YP Click here to enter text.  DoB: Click here to enter text.  Child/YP Click here to enter text.  DoB: Click here to enter text.  Previous CFCS involvement: : ☐ Yes ☐ No |
| *Please briefly describe your concerns.* | |
| *For CFCS use only*  Date processed:Click here to enter text.  Allocated to*:* Click here to enter text.  Consultation date/time offered: Click here to enter text. | |

###### Please email the form to [NewhamCFCS@elft.nhs.uk](mailto:NewhamCFCS@elft.nhs.uk)

###### and use the subject heading ‘Consultation request’ in your email

###### Please attach relevant documents (e.g. (CP/CIN plan, reports, assessment)

Thank you for request. You will be contacted within 2 weeks of requesting a consultation.