



Integrated

Report/Referral Form

**Do you have any safeguarding concerns for children or adults or allegations/concerns of Professional Abuse?**

If yes, the concerns need to be shared immediately by telephone with:

* Relevant partner agency
* Police (999/101)
* Social Services (number at the end of form)
* NHS Corporate Safeguarding (01639 683164)

**IT IS EVERY PERSONS RESPONSIBILITY TO REPORT A CONCERN**

For 3rd sector/Universal Services, please visit <https://www.dewis.wales>

Do you consider this referral to be for:

* Early Intervention and Prevention and Community Support Services [ ]
* Safeguarding Concerns [ ]
* Adult at Risk [ ]

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| *Place X in the box to confirm this has been discussed and agreed with the referred* *person / child / parent.* |
| The person confirms that the details given in this referral form have been discussed and shared with them and understand the reasons for the referral. |  |
| The person understands that the referral will be submitted to the Single Point of Contact (SPOC) or Common Access Point (CAP)to consider next steps (i.e. Information, Advice, Assistance or Assessment). |  |
| The person understands that information gained about them as part of this referral, assessment and ongoing support will be shared with key partner agencies. |  |
| The person authorises the SPOC/CAP contacting key agencies as listed on page 3, for the purpose of making enquiries about my support needs.  |  |
| If no authorisation has been given, please state reason(s) below why this should proceed to a referral. If person lacks mental capacity please detail in Section 5.  |
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* Allegations/Concerns of Professional Abuse[ ]

**AUTHORISATION**

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| **Name and/or Signature of the person referred**(if there is a power of attorney for health and welfare in place please gain their authorisation and ask them to sign on behalf of the person)(if the child is under 18 please ask a parent / guardian to sign below)(children 16 or above who do not have a parent / guardian can sign themselves) | **Date** |
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| **Section 1**  | **Referrer Details** |
| **Date of referral** |  |
| **Name of referrer (including designation)** |  |
| **Agency details (including contact address)** |  |
| **Full Telephone number** |  |
| **Email address** |  |

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| **Section 2**  | **Details of the Individual(s)** |
| **Name** | **Gender** | **D.O.B** | **Language** | **Ethnicity** | **Status** |
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| **Full Home Address****(If the individual is in hospital please also state which hospital and ward)** |  |
| **Home Telephone Number** |  | **Mobile Telephone Number** |  |
| **Preferred Language** |  |
| **Tenure, accessibility to the home and accommodation type.** | (This information is particularly important if referring for aids and adaptations to the home) |
| **Please confirm if the property is:** |
| Privately Owned |  | Privately Rented |  | Tai Tarian Property |  |
| For other property type, please specify: |
| **Does the person consider themselves to have a disability?**   | **YES -** If yes, please give full details in the ‘Persons Circumstances’ section below. |
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| **Section 3**  | **Family Members** |
| **Family****Member** *Relationship* | **Main Carer/ Emergency Contact/ PR** | **First Name** | **Surname** | **DOB** | **Address and Telephone No** |
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| **Section 4**  | **Key Agency involvement with the person and their family** **(e.g. school, GP please state if previous or current)** |
| **Agency** | **Contact Name** | **Telephone No./Email** | **Previous/Current** | **Supporting** *(name of family member)* |
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| **Section 5** |
| 1. **Persons Circumstances (Reasons for referring)**
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| 1. **Personal Outcomes**

 *What outcomes does the person want to achieve?* *What outcomes do the carers / family want to achieve?* *What support do you think the person requires?* |
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| 1. **Strengths/ Capabilities–** *Please identify what strengths you or the person / parent / child has identified.*
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| 1. **Risks –** *Please detail the risks identified, what the family’s views are and the views of the referrer regarding the*

*specific risks to include harm outside of the family (Contextual risk: Person, Place, Premises).* |
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| 1. **Barriers –** *Please detail the barriers i.e. what is stopping the person / parent / child achieving what matters to them.*
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| **5(f) Are you aware of any risk(s)?** (*e.g. dangerous dogs, violent persons, syringes)* |
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**For concerns of allegations of professional abuse**

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| **Section 6**  | **About the person(s) responsible for the alleged abuse** |
| **Name:** |  | **Address:** |  |
| **Tel. No.**  |  | **Date of Birth:** |  | **Age:** |  |
| **Are there any children or vulnerable adults in the household?** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Employment Status:** |  |
| **Employing Agencies. List all known.** |  | **Role:** |  |
| **Employer Contact Details** | **Employer** **Address:** |  | **Contact Name:** |  | **Tel. No:** |  |
| **Secondary or voluntary employment Address:** |  | **Contact Name:** |  | **Tel. No:** |  |
| **Does the alleged person of concern have any contact with children/ adults in any employment role?** | **Child** | Yes [ ]  | No [ ]  | N/K [ ]  |
| **Adult** | Yes [ ]  | No [ ]  | N/K [ ]  |
| **Is alleged person of concern an adult at risk?****If yes, please submit a separate referral** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Is the alleged person of concern aware of the referral?** | Yes [ ]  | No [ ]  | Don’t know [ ]  |
| **If there is more than one alleged person in this section, copy and repeat for any other persons** |

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| **Section 7**  | **Was the incident witnessed?** |
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| **WITNESS 1** |
| **Name:** |  | **Address:** |  |
| **Tel. No.**  |  |
| **Relationship to victim:** | Paid Employee [ ]  | Volunteer/ Unpaid employee [ ]  | Relative/ Friend [ ]   | Other ServiceUser [ ]  | Other [ ]  |
| **Is witness a child?** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Is witness aware of referral?** | Yes [ ]  | No [ ]  | Don’t know [ ]  |

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| **WITNESS 2** |
| **Name:** |  | **Address:** |  |
| **Tel. No.**  |  |
| **Relationship to victim:** | Paid Employee [ ]  | Volunteer/ Unpaid employee [ ]  | Relative/ Friend [ ]  | Other ServiceUser [ ]  | Other[ ]  |
| **Is witness a child?** | Yes [ ]  | No [ ]  | Don’t Know [ ]  |
| **Is witness aware of referral?** | Yes [ ]  | No [ ]  | Don’t know [ ]  |

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| **For Neath Port Talbot Referrals****please return completed form to:****Adults and Children’s Single Point of Contact**Tel: 01639 686802Email: spoc@npt.gov.uk | **For Swansea Information, Advice and Assistance Team, please return completed form to:** **For Child Reports/Referrals**Tel:01792 635700Email: singlepointofcontact@swansea.gov.uk **For Adult Reports/Referrals**Tel: 01792 636519Email: CAP@swansea.gov.uk  |
| **For all referrals from a Health Professional, please send a copy to** SBU.Safeguarding@wales.nhs.uk  |

**P*referred option for non-urgent professional referrals is email***