



Common Assessment Framework

Referral Form

Professionals wishing to complete a Common Assessment Framework (CAF) should complete this form.

The form is intended to reduce the need for multiple referrals for families and to ensure that Isles of Scilly Children and Young People's Services has the fullest available information when making decisions about the appropriate response to any CAF referral. The form should be completed as fully as your knowledge or information allows. Please mark any sections you are unable to complete as "not known".

IF THE CONCERNS ARE OF AN URGENT NATURE (i.e. a child appears to be suffering or likely to suffer significant harm) Children and Young People's Social Care Services **MUST** be contacted **IMMEDIATELY** by **TELEPHONE** - you do NOT need to fill in the form. Any further information required from you will be sought later by Children's Social Care.

For any queries or further information please contact: The Children and Young People's CAF Co-ordinator on **(01720) 424354** or **(01720) 423680**

Child or young person being assessed

Name			Contact Phone number/s	Home
				Mobile
Previous name			Also Known as	
Date of Birth/EDD (Expected Due Date)		Male <input type="checkbox"/> Female <input type="checkbox"/>	CAF number (e.g. 1 st , 2 nd)	
Address			Postcode	
Immigration status				
Religion				
Ethnicity – please select				
Any other Ethnic group <input type="checkbox"/>	Any other mixed background <input type="checkbox"/>	Any other white background <input type="checkbox"/>	Asian/Asian British –any other Asian background <input type="checkbox"/>	Asian/Asian British - Bangladeshi <input type="checkbox"/>
Asian/Asian British - Indian <input type="checkbox"/>	Asian/Asian British - Pakistani <input type="checkbox"/>	Black/Black British-African <input type="checkbox"/>	Black/Black British – any other Black background <input type="checkbox"/>	Black/Black British-Caribbean <input type="checkbox"/>
Chinese <input type="checkbox"/>	Mixed-white & Asian <input type="checkbox"/>	Mixed-White & Black African <input type="checkbox"/>	Mixed-White & Black Caribbean <input type="checkbox"/>	Not stated <input type="checkbox"/>
White British <input type="checkbox"/>	White Irish <input type="checkbox"/>			

Does the child have a disability?	YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, give details	
Are there any language or communication needs?			

Parents/carers including all persons with parental responsibility

Name and relationship to unborn baby, child or young person:	Name and relationship to unborn baby, child or young person:
Address:	Address:
Contact Number: Permission to contact? Yes <input type="checkbox"/> No <input type="checkbox"/>	Contact Number: Permission to contact? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does this parent/carer have parental responsibility? Y <input type="checkbox"/> N <input type="checkbox"/>	Does this parent/carer have parental responsibility? Y <input type="checkbox"/> N <input type="checkbox"/>

Parents/carers including all persons with parental responsibility

Name and relationship to unborn baby, child or young person:	Name and relationship to unborn baby, child or young person:
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Does this parent/carer have parental responsibility? Y <input type="checkbox"/> N <input type="checkbox"/>	Does this parent/carer have parental responsibility? Y <input type="checkbox"/> N <input type="checkbox"/>

Details of siblings

	DOB	Age
Name and relationship		
Name and relationship		
Name and relationship		
Name and relationship		
Name and relationship		

Do any siblings have additional needs? Yes No

If yes, please give further details:

Person(s) initiating CAF

Name		Contact Phone No.	
Address			
E-mail address			
Job title/role		Agency	

Assessment information

Date of assessment	
People present at assessment	

What is the main reason that this assessment is taking place? (Please **TICK** only ONE box).

Health issues-Young person <input type="checkbox"/>	Health issues-Family <input type="checkbox"/>	Healthy lifestyle issues <input type="checkbox"/>	Speech/language delay <input type="checkbox"/>	Sexuality issues <input type="checkbox"/>	Sexual health concerns <input type="checkbox"/>	Mental health issues- Young person <input type="checkbox"/>	Mental health issues-Family <input type="checkbox"/>
Emotional wellbeing issues <input type="checkbox"/>	Low self esteem <input type="checkbox"/>	Self harm <input type="checkbox"/>	Bereavement <input type="checkbox"/>	Learning disability – Family <input type="checkbox"/>	Learning disability – Young person <input type="checkbox"/>	Physical disability-Young person <input type="checkbox"/>	Physical disability-Family <input type="checkbox"/>
Sibling of a child with a disability <input type="checkbox"/>	Poor/non school attendance <input type="checkbox"/>	Home/school liaison difficulties <input type="checkbox"/>	School exclusion <input type="checkbox"/>	Behavioural issues/ concerns <input type="checkbox"/>	Anti-social behaviour <input type="checkbox"/>	Offending behaviour (current) <input type="checkbox"/>	Offending behaviour (risk of) <input type="checkbox"/>
Bullying (victim of) <input type="checkbox"/>	Bullying (of others) <input type="checkbox"/>	Substance misuse-Young person <input type="checkbox"/>	Substance misuse-Family <input type="checkbox"/>	Domestic abuse-Young person <input type="checkbox"/>	Domestic abuse-Family <input type="checkbox"/>	Family relationship difficulties <input type="checkbox"/>	Other relationship difficulties <input type="checkbox"/>
Parenting concerns <input type="checkbox"/>	Young person acting as carer <input type="checkbox"/>	Teenage parent/ pregnancy <input type="checkbox"/>	Pregnancy - Parent/carer <input type="checkbox"/>	Young person at risk of becoming homeless <input type="checkbox"/>	Young person is homeless <input type="checkbox"/>	Housing/ accommodation issues – Family <input type="checkbox"/>	Ethnicity/ heritage issues <input type="checkbox"/>
Significant financial hardship <input type="checkbox"/>	Social isolation <input type="checkbox"/>	Transition <input type="checkbox"/>	Other, please specify:				

Are there any other reasons why this assessment is taking place? (please **TICK** all that apply)

Health issues-Young person <input type="checkbox"/>	Health issues-Family <input type="checkbox"/>	Healthy lifestyle issues <input type="checkbox"/>	Speech/language delay <input type="checkbox"/>	Sexuality issues <input type="checkbox"/>	Sexual health concerns <input type="checkbox"/>	Mental health issues- Young person <input type="checkbox"/>	Mental health issues-Family <input type="checkbox"/>
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Services working with this child or young person

	Include name, agency, address, e-mail address and contact telephone number
Early years/School/post 16 provision	
GP	
Other professionals and agencies working with this child or young person	

Assessment summary

	Element	Comment – identify <u>strengths and needs</u> and where possible identify parents/carers capacity to meet those needs.	Level of need i.e. S=Strengths U=Universal V=Vulnerable C=Complex A=Acute
Development of child or young person	Health General health Physical development Speech, language and communications		
	Emotional and social development		
	Behavioural development		
	Identity, including self-esteem and self-image and social presentation		
	Family and social relationships		
	Self-care skills and independence		
	Learning Understanding, reasoning and problem solving Progress and achievement in learning Participation in learning, education and employment		

	Aspirations		
Parents and Carers	Basic care, ensuring safety and protection		
	Emotional warmth and stability		
	Guidance, boundaries and stimulation		
Family & Environment	Family history, functioning and well-being		
	Wider family		
	Housing, employment and financial considerations		
	Social & community elements and resources, including education		

Please refer to the Children's Social Care Tier of Need Model and indicate the overall level of need (*please TICK*)

Universal Additional Complex Acute

Based on your assessment of need, which of the five outcomes do you feel this child/young person will not meet without further support? (*please TICK*)

Be Healthy Stay Safe Enjoy and Achieve Make a Positive Contribution Achieve Economic Well Being

RECORD ANY MAJOR DIFFERENCES OF OPINION

What are your conclusions? E.g. strengths, no additional needs, additional needs, complex needs, risk of harm to self or others. What action is needed?

What would you like to happen?

What are we going to do? e.g. tasks for you, the child or young person and their family	By when?

Do you need to involve other agencies to meet the needs of this child/young person? YES NO

If you cannot meet the child or young person's needs you must convene a Team around the Child (TAC) meeting.

TAC Details

Proposed Dates/Times for the TAC meeting (please supply a minimum of 3 dates)	Date/s: 1 st 2 nd 3 rd												
	Time/s:												
	Venue/s please TICK :												
	<table border="1"> <tr> <td>Children's Centre <input type="checkbox"/></td> <td>School Base <input type="checkbox"/></td> </tr> <tr> <td>Health Centre Conference Room <input type="checkbox"/></td> <td>Church Pavilion <input type="checkbox"/></td> </tr> <tr> <td>Wesleyan Chapel <input type="checkbox"/></td> <td>Home <input type="checkbox"/></td> </tr> <tr> <td>Children's Social Care Meeting Room <input type="checkbox"/></td> <td>Other please specify:</td> </tr> </table>	Children's Centre <input type="checkbox"/>	School Base <input type="checkbox"/>	Health Centre Conference Room <input type="checkbox"/>	Church Pavilion <input type="checkbox"/>	Wesleyan Chapel <input type="checkbox"/>	Home <input type="checkbox"/>	Children's Social Care Meeting Room <input type="checkbox"/>	Other please specify:				
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Is this child/young person receiving services from more than one local authority?	Y <input type="checkbox"/> N <input type="checkbox"/>												
Special Information regarding the family e.g. disabilities, working times, childcare problems etc													
Any other relevant information e.g. parents at separate addresses													
Who do you want to invite to your TAC meeting? Please TICK	<table border="1"> <tr> <td>Child <input type="checkbox"/></td> <td>Parent/carer <input type="checkbox"/> Name/s:</td> </tr> <tr> <td>Early Years/Youth <input type="checkbox"/></td> <td>School (please specify individual/s)</td> </tr> <tr> <td>Post 16 Support <input type="checkbox"/></td> <td>GP <input type="checkbox"/></td> </tr> <tr> <td>Health Visitor <input type="checkbox"/></td> <td>Mid wife <input type="checkbox"/></td> </tr> <tr> <td>Connexions Worker <input type="checkbox"/></td> <td>Housing Officer <input type="checkbox"/></td> </tr> <tr> <td>Social worker/(Family</td> <td>YOT <input type="checkbox"/></td> </tr> </table>	Child <input type="checkbox"/>	Parent/carer <input type="checkbox"/> Name/s:	Early Years/Youth <input type="checkbox"/>	School (please specify individual/s)	Post 16 Support <input type="checkbox"/>	GP <input type="checkbox"/>	Health Visitor <input type="checkbox"/>	Mid wife <input type="checkbox"/>	Connexions Worker <input type="checkbox"/>	Housing Officer <input type="checkbox"/>	Social worker/(Family	YOT <input type="checkbox"/>
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	Support) <input type="checkbox"/>	
	CAHMS worker <input type="checkbox"/>	Childcare Provider <input type="checkbox"/>
	Portage worker <input type="checkbox"/>	Police <input type="checkbox"/>
	Lifelong Learning <input type="checkbox"/>	Adult services <input type="checkbox"/>
	Other please specify:	

RECORD ANY MAJOR DIFFERENCES OF OPINION

Is child/young person invited to the TAC meetings? YES NO
 If not, why not?

LEAD PROFESSIONAL

Who do you want to ask to be your Lead Professional?

1 st Choice	Name:	Role:
2 nd Choice	Name:	Role:
3 rd Choice	Name:	Role:

Child or young person's comment on the assessment and actions identified:

Parent/carer's comment on the assessment and actions identified:

Copy given to Child/Young Person YES NO Date:

Copy given to the Parent/Carer YES NO Date:

Consent for information storage and information sharing

I understand the information that is recorded on this form and that it will be stored and used for the purpose of providing services to:

- Me
- This child or young person for whom I am a parent
- This child or young person for whom I am a carer

I have had the reasons for information sharing explained to me and I understand those reasons

I agree to the sharing of information between relevant professionals and services: YES NO

If no, please list which agencies are **NOT** permitted

Other known assessments e.g. SEN:

I agree to the sharing of these assessments between relevant professionals and services: YES NO

If no, please list which agencies are **NOT** permitted

Parent/Carer		Signature		Date	
Young Person		Signature		Date	
CAF initiator		Signature		Date	

For the CAF initiator: please date and highlight when the Common Assessment Framework Referral form has been sent to the Children's and Young People's CAF Co-ordinator:

Date: _____ Please **TICK** method sent by: e-mail Hand delivered Posted

CAF Reference Number: