Referral Form & Risk Assessment



**Important Information:**

Please complete the form with as much detail as possible. **Failure to complete the referral in full may result in your referral being returned, which may delay your referral being processed.** If you are unsure of any personal details, please leave these blank and we will obtain the information from the other party.

Upon receipt of the referral, **it may take up to five working days to review your request**. As part of our reviewing process, we may speak to other parties to clarify the information provided and send them a copy of the referral we have received. Any misleading or incorrect information should be clearly marked on the referral form and/or discussed with Connections.

If your referral is accepted, you will be asked to pay a one-off non-refundable £50 admin fee. **Please note, payment is required 72 hours prior to contact, otherwise contact will be cancelled.** Both parties must familiarise themselves with the Contact Agreement which can be found on our website.

*If you have any further questions or require support in completing your referral, please contact us on 07554 941 881.*

**Completed referrals should be sent to**: admin@connectionscontactservices.co.uk

**Prices:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Supervised Contact:** | **Supported Contact:** | **Assisted Handover:** | **Virtual Contact:** |
| **£46 p/h** (Monday-Friday – Community/Activity based)  **£50 p/h** (Saturday – Sunday – Community/Activity based)  **\*An additional £20 p/h is added if contact needs to take place in the centre – this covers the cost of the room hire\*** | **£46 p/h** (Monday-Friday – Community/Activity based)  **£50 p/h** (Saturday – Sunday – Community/Activity based)  **\*An additional £20 p/h is added if contact needs to take place in the centre – this covers the cost of the room hire\*** | **Please enquire -** (Prices vary depending on circumstances). | **£25 per session** (Up to 30 minutes) |

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| --- | --- | --- | --- |
| **Optional Extras:** |  | **Optional Extras:** |  |
| **Contact reports:**  £15 per report – Supervised Contact.  £8 per report – Handover and Virtual Contact Reports. | This is the same charge no matter how long the contact is for. | **Transport/Travel Costs:** £24 p/h  **Contact Worker Mileage:** £0.50 (per mile) | We are able to transport children to and from contact if required. Please note that travel time will be calculated beforehand by Connections. Travel costs are also calculated for contacts in the community. |

**Personal Details:**

**Referrer Details: (e.g Social worker / CAFCASS)**

|  |  |
| --- | --- |
| Referrer name: |  |
| Role/Employer: |  |
| Referrer address and postcode: |  |
| Telephone: |  |
| Email: |  |

## Details of Parent(s)/Adult(s) Who Is Requesting Contact:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Relationship to child(ren): |  | | |
| Address: |  | | |
| Postcode: |  | Ethnicity: |  |
| Telephone: |  | | |
| Email (invoices will be sent via email) |  | | |

|  |  |
| --- | --- |
| Solicitors Name and Practice (if applicable): |  |
| Telephone number: |  |
| Email address: |  |

**Children’s Details:**

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| --- | --- | --- | --- | --- |
| Child(ren) Name(s) | Age | Date of Birth | Male/ Female | Ethnicity |
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| --- | --- |
| Who does the child live with? |  |
| Who has parental responsibility? |  |

## Details of Carer(s)/Adult(s) Who The Child Lives With / Resident Party:

|  |  |  |  |
| --- | --- | --- | --- |
| Name(s): |  | | |
| Relationship to child(ren): |  | | |
| Address: |  | | |
| Postcode: |  | Ethnicity: |  |
| Telephone: |  | | |
| Email: |  | | |

|  |  |
| --- | --- |
| Solicitors Name and Practice (if applicable): |  |
| Telephone number: |  |
| Email address: |  |

|  |  |  |
| --- | --- | --- |
| Is an interpreter needed for contact? If yes, this must be agreed through an independent organisation and must not be friends or family. **Please note, the arrangement and cost of any interpretation service is not the responsibility of Connections.** | Yes | No |

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| --- | --- | --- |
| Does the child/young person or either party have an allergy, medical condition, disability, learning or behavioural difficulties that Connections need to be aware of? | Yes | No |
| **If yes, please give details:** | | |

**Important Information:**

|  |  |  |
| --- | --- | --- |
| Is there, or has there been any other agencies involved? (For example, Social Care, CAFCASS, etc) **If yes, please provide full contact details for all professionals.** | Yes | No |
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| Is there a court order relating to contact? (If yes, Connections must be provided with a copy) | Yes | No |
| **Details of court order**: | | |
| Are there any *other* court orders that have been made in relation to the child(ren) and if so, when? (e.g. where a child is to reside) | Yes | No |
| **Details**: | | |

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| --- |
| Why does the contact need to be supervised? **(Please give details, e.g. concerns of abuse, history of substance misuse, violence, no contact for some time. This section must be completed in detail. Include any prior convictions/cautions committed by either party)** |
|  |

**Booking Request:**

|  |  |
| --- | --- |
| **Type of contact required: (mark with ‘X’/‘Yes’)** | |
| **Supervised Contact:** |  |
| **Supported Contact:** |  |
| **Assisted Handover:** |  |
| **Virtual Contact:** |  |

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| **Is a report required after each session?** *(Please note, these are £15 each)* |  |
| **Does contact need to take place in a contact room?** |  |

|  |  |
| --- | --- |
| Preferred **Date** and **Time** of contact? (subject to availability)  *If specific dates are required, please include these here…* |  |
| Frequency of contact?  E.g. Weekly, Fortnightly, Monthly, One-off contact. |  |
| Duration of contact? *(How many hours per contact)* |  |
| For contacts taking place on a regular basis, how many weeks/number of contacts do you wish to book? |  |
| Who is funding contact? (*Who shall Connections invoice for payments? If a Local Authority is funding contact, please provide the email address which invoices should be sent to)* |  |
| Name(s) of all the people who are able to attend contact and their relationship to the child:  **(Should anyone attend contact who has not been formally agreed to attend by both parties prior to contact, they will be asked to leave and if they refuse, contact will be terminated)** | |
| Please provide names and email addresses for all who require a copy of the contact report/summary (if required)? | |
| For supervised contact, is there anything that Contact Supervisors specifically need to observe/assess or should pay close attention to? | |

|  |  |  |
| --- | --- | --- |
| Can contact take place out in the community/be activity based? | Yes | No |
| Are there any restrictions as to where contact can take place? E.g Family member’s home, specific activity, etc. **Please note, our Contact Supervisors need to remain in close proximity, however not all conversations are guaranteed to be heard. Certain activities such as ice-skating, swimming, etc is prohibited. All activities must be agreed by Connections.** | | |
| Can photographs/videos be taken during contact? | Yes | No |
| Can the child talk to/message anyone not present on the phone?  **Details**: | Yes | No |
| Can the non-resident party take the child to the toilet? | Yes | No |
| Are the resident and non-resident party willing to meet? *(If not, an assisted handover can be put in place)* | Yes | No |
| Will the adult with whom the child(ren) resides with be bringing them to and collecting them from contact?  **If no, details of person bring/collecting child:** | Yes | No |
| Is transport required before and/or after contact? | Yes | No |
| **If yes, details of transport requirements, including addresses.** | | |
| Please use this space to provide any further details or requests regarding contact. **Connections reserve the right to contact all parties for further information and clarity if required:** | | |

**Previous Contact:**

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| When and where did contact last take place? If this stopped, what were the reasons for this? |
| Have the family ever used another contact service? Please provide the name of the centre and dates used: |

Please continue to next page to complete Risk Assessment:

**Risk Assessment**

|  |  |  |
| --- | --- | --- |
| Are there on-going criminal investigations or pending Findings of Fact at the time of referral? **Please give details below:** | Yes | No |
| Are any of the children involved currently subject to a Child Protection Plan or other Local Authority involvement? **Please give details below:** | Yes | No |
| Has any person who will be involved in the contact ever been convicted of an offence against child(ren)? **If yes, please give details below:** | Yes | No |
| Please give details of any undertakings, injunctions or convictions relating to violence involving either party, their respective families or the children: | Yes | No |

**Please provide further detail and information if ‘Yes’ or ‘Allegation’ has been identified. All sections must be completed. Space to provide detail regarding potential risks is available below.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Potential Safeguarding Risk:** | **Yes** | **No** | **Allegation** |
| Physical Abuse: |  |  |  |
| Sexual Abuse: |  |  |  |
| Emotional Abuse: |  |  |  |
| Neglect: |  |  |  |
| Risk of Abduction: |  |  |  |
| Domestic abuse: |  |  |  |
| Conflict between adults/parents: |  |  |  |
| Alcohol abuse: |  |  |  |
| Drug/substance abuse: |  |  |  |
| Mental health issues: |  |  |  |
| Cultural/Religious issues: |  |  |  |
| Immigration / asylum: |  |  |  |
| Financial issues: |  |  |  |
| Medical/Health condition of adult/child: |  |  |  |
| Physical impairments adult/child: |  |  |  |
| Learning difficulties adult/child: |  |  |  |
| Parenting skills: |  |  |  |
| Adult influencing child’s views |  |  |  |
| Involvement of other family members in the contact: |  |  |  |
| Risk of violence towards staff: |  |  |  |
| Risk of volatile behaviour: |  |  |  |
| Risk of self-harm: |  |  |  |
| Other (please specify): |  | | |

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| **Further information/detail regarding Risk Assessment:** |

**I confirm that the answers I have provided in this document are true to the best of my knowledge. I understand that any information deliberately concealed may result in Connections Contact Services refusing to facilitate contact. I understand that all information provided to Connections Contact Services will be used for the sole purpose of the facilitation of contact.**

**(If completed by a social worker or CAFCASS, please sign the first box)**

|  |
| --- |
| **Referrer:** |
| Name: |
| Signature: |
| Date: |

|  |  |
| --- | --- |
| **Non-resident Party:** | **Resident Party:** |
| Name: | Name: |
| Signature: | Signature: |
| Date: | Date: |

Please send completed Referral Form to **admin@connectionscontactservices.co.uk**