**Child protection medical assessment referral:**

**South Tees Hospitals NHS Foundation Trust**

This form should be used to refer children and young people for consideration for a child protection medical assessment at South Tees Hospitals NHS Foundation Trust.

Referrals will be reviewed on **weekdays between 0900 and 1700**. Referrers must be aware that referrals made out of hours and at weekends or bank holidays using this form will not be reviewed until the next working day and therefore appropriate supervision arrangements should be made for the child(ren) or young people. If an urgent children protection medical assessment is required between 1700 and 0900 on weekdays, or on weekends or bank holidays, please contact James Cook University Hospital (01642 850850) and ask for the consultant paediatrician on call.

Please complete all appropriate details on this form and email [stees.childprotectionreferrals@nhs.net](mailto:stees.childprotectionreferrals@nhs.net). If you have not received an email acknowledging receipt of the referral within 30 minutes of sending the email, or if you need to speak to the administration team, please contact 07977 047614 Monday to Friday 0900 to 1700.

If you require the advice of a consultant paediatrician regarding the suitability of a child protection medical assessment, please ring 07977 047614 Monday to Friday 0900 to 1700. For urgent advice out of hours, please contact the consultant paediatrician on call at James Cook University Hospital.

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| **Referral.**  *Please complete all details at the point of referral. Please do not refer until you are confident that a child protection medical assessment will be required.* | | | |
| Date of referral |  | Time |  |
| Referrer’s name |  | | |
| Designation |  | Agency |  |
| Phone |  | Email |  |
| Allocated social worker *(if different from referrer)* | |  | |
| Phone |  | Email |  |

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| **Child/young person’s details** *(one child per form – please complete new form if more than one child)* | | | |
| Name |  | DOB |  |
| Address |  | | |
| School/nursery |  | GP |  |
| Who has parental responsilbility? | |  | |
| Who is the primary caregiver? | |  | |

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| **Reason for referral** | | | | | |
| Has a strategy meeting been held? | Yes |  | | Date |  |
| No |  | | | |
| *If not, why?* | | |  | |
| Has a social worker been to visit the child? | Yes | |  |  | |
| No | |  |  | |
| *If not, is there a plan to?* | | |  | |
| Has it been identified that a person with parental responsibility will be available to provide consent? *Consent for the assessment will be undertaken by the examining doctor but an agreement in principle is required to book the medical.* | Yes |  | | Who? |  |
| No |  | | | |
| *If not, why?* | | |  | |
| Please outline why you feel a child protection medical assessment is required. *Please include specific details relating to any incidents.* | | | | | |
|  | | | | | |

Once completed, please email this form to [stees.childprotectionreferrals@nhs.net](mailto:stees.childprotectionreferrals@nhs.net)

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| **South Tees NHS Foundation Trust.** *To be completed by hospital staff* | | | | | | | | |
| Hospital number |  | | | | NHS |  | | |
| Secretary name |  | | | | Email |  | | |
| Date received |  | | | | Time |  | | |
| Paediatrician |  | | | | | | | |
| Medical booked? | Yes |  | Date |  | Time |  | Location |  |
| No |  | | | | | | |
| Documentation of discussions/decision-making. *Outline of discussions between health and social care staff and rationale for decision-making, including reasons why a medical is not required if appropriate. Discussions between medical staff and social care must be documented in the patient notes.* | | | | | | | | |
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