

**Unborn Referral to Family Group Conference Service**

Name of Social Worker ……………………………………………

Phone Number ………………………….

|  |  |  |
| --- | --- | --- |
| **P Number** |  | |
| **EDB** |  | |
| **Ethnicity** |  | |
| **Address** |  | |
| **Name(s) and telephone numbers of parent/s** |  | |
| **First language** |  | |
| **Any special needs or disability** |  | |
| **Siblings names (if applicable)** |  | |
| **Legal status (Care Order, etc)** |  | |
| **Is the child or young person subject to a Child Protection Plan** | | **Yes**  **No** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Background/Current Situation** |  | | |
| Are there any safety risks the FGC should be aware of? | | | **Yes  No** |
| Referrer contact details: | |  | |

**You will be contacted by the allocated FGC facilitator.**

**Please email completed form to FGCT email inbox**