

**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** **[ ]**  |

|  |  |
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| **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**