Telford & Wrekin Safeguarding Children Board

SCB PARTNER AGENCY REFERRAL FORM
ALLEGATIONS MADE AGAINST A PERSON WORKING WITH CHILDREN

Name of SCB Partner Agency Referring:	**Referrer Name:**
Address:	
Position:	
Tel and Fax Number:	
Date & Time:	

1. SUBJECT DETAILS **Name of person allegation has been made against:** **Is the person aware that the allegation has been made YES/NO**	**DOB** **CRB YES/NO**	**Name of person/child making allegation:** **DOB (if known)** **Is the referral a request for the SCB to Chair a Strategy Meeting? YES/NO** **If not who is Chairing the meeting?** **Name:**
Home Address: **Post Code:**		**Home Address:** **Post Code:**

2. REFERRAL/CONCERNS- DETAILS

3.ACTION/ADVICE GIVEN TO DATE AND ANY AGENCIES INFORMED

Signature: **Print Name:** **Date:**

4. LADO USE ONLY

NAME:	**DATE/TIME RECEIVED:**
POSITION:	
ACTION TO BE TAKEN:	