## **Referral form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **In respect of allegations about people in a position of trust working with adults at risk** | | | | | |
| TO BE COMPLETED WITHIN 24 HOURS OF BECOMING AWARE OF THE CONCERN | | | | | |
|  | | | | | |
| **Details of person making referral** | | | | | |
| **Date of referral:** |  | | | | |
| **Referrer name:** |  | | | | |
| **Referrer Contact Details:** |  | | | | |
|  | | | | | |
| **Details of Person in Position of Trust (against whom allegations have been made)** | | | | | |
| **Name of Person in a Position of Trust:** | **Surname:** | **First Name:** | | **Mr / Mrs / Ms / Miss** | **Alias:** |
| **Date Person has been notified of concern** |  | | | | |
| **Date of Birth:** |  | | | | |
| **Home Address:** |  | | | | |
| **Current Job Role and brief description of responsibilities:** |  | | | | |
| **Employing Agency:** |  | | | | |
| **Length of Service in current post:** |  | | | | |
| **Previous Employment and Job Role:** |  | | | | |
| **Have any allegations been made against this individual previously?** | | | | | |
| Yes No Not Known | | | | | |
| If yes, please specify | | | | | |
|  | | | | | |
| **Details of adults (s) with care and support needs – to whom the allegation relates** | | | | | |
|  | **Adult 1** | | **Adult 2** | **Adult 3\*** | |
| **Name:** |  | |  |  | |
| **D.O.B:** |  | |  |  | |
| **URN: If applicable** |  | |  |  | |
| **Home Address:** |  | |  |  | |
| **Care Homes Address**  **(if applicable):** |  | |  |  | |
| **Ethnicity:** |  | |  |  | |
| **Relationship to Adult:** |  | |  |  | |
| *(\*If there are more than 3 children/adults – please add details at the end of this referral)* | | | | | |
| **Does this individual pose a risk to children in their employment setting or in any other way? If yes, please specify:** | | | | | |
|  | | | | | |
| **Details of child(ren) who live in the same household as Person in Position of Trust** | | | | | |
|  | **Child 1** | | **Child 2** | **Child 3\*** | |
| **Name:** |  | |  |  | |
| **D.O.B:** |  | |  |  | |
| **ID code *(if known):*** |  | |  |  | |
| **Address:** |  | |  |  | |
| **Ethnicity:** |  | |  |  | |
| **Relationship to Adult:** |  | |  |  | |
| *(\*If there are more than 3 children/adults – please add details at the end of this referral)* | | | | | |
|  |  | |  |  | |
| **Information about the allegation or behavior causing concern** | | | | | |
| **Date of alleged incident:** |  | | | | |
| **Date information became known to referrer:** |  | | | | |
| **Description of allegation/details of concerns:**  *(Please provide full names of any person referenced within this referral, not initials)* |  | | | | |
| **Any other known positions of trust held?** *(Please include paid and voluntary roles)* |  | |  |  | |
| **Other agencies involved and contact details:** |  | |  |  | |
| **Action taken by Organisations/Employers to date:** |  | |  |  | |
| **\*Details of other relevant children/adults if you need to list more than 3:** | | | | | |
| **AWDO contact details:**  Email: [SPOR@health.gov.je](mailto:SPOR@health.gov.je)  Tel: 01534 444 440 | | | | | |