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**ADOPTION CONSULTATION**

**REFERRAL FORM**

*Part 1: Contact Details – To be completed by the Allocated Social Worker*

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| --- | --- |
| **Name of Child** |  |
| **Date of Birth** |  |
| **NHS Number** |  |

|  |  |
| --- | --- |
| **Name of Allocated Social Worker** |  |
| **Email** |  |
| **Telephone** |  |

|  |  |
| --- | --- |
| **Name of Prospective Adopter(s)** |  |
| **Email(s)** |  |
| **Telephone** |  |
| **Date of Proposed Matching Panel** |  |

|  |  |
| --- | --- |
| **Name of Supervising Social Worker** |  |
| **Name of Adoption Agency** |  |
| **Email** |  |
| **Telephone** |  |

*Part 2: Questions of the prospective adopters – To be requested by the allocated social worker in advance and copied here.*

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*Part 3: Consultation Details – To be completed by St George’s Hospital staff upon booking, and returned to the allocated social worker, Principal Business Support, and Permanency Champion Manager.*

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| --- | --- |
| **Date** |  |
| **Time** |  |
| **Location**  *(Please include address or note if virtual)* |  |
| **Medical Advisor undertaking the consultation** |  |
| **St Georges staff contact**  *(Name/contact details)* |  |

|  |  |
| --- | --- |
| **Signature of Social Worker**  *(at time of request)* |  |
| **Name** *(in print)* |  |
| **Date** |  |