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**ADOPTION MEDICAL ASSESSMENT**

**REFERRAL FORM**

*Form to be completed by the Child’s Allocated Social Worker and sent to the Principal Business Support Officer and Permanency Champion Manager. Please ensure that all documents provided are available on the child’s Mosaic record.*

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| **Name of Child** |  |
| **Date of Birth** |  |
| **Place of Birth / Hospital Name** |  |
| **NHS Number** |  |

|  |  |
| --- | --- |
| **Name of Mother** |  |
| **Date of Birth** |  |

|  |  |
| --- | --- |
| **Name of Father** |  |
| **Date of Birth** |  |

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| --- | --- | --- | --- |
| **Documents** | **Yes** | **No** | **Reason if not provided** |
| BAAF Form M (maternity) |  |  |  |
| BAAF Form B (neonatal) |  |  |  |
| BAAF Form PH (mother) |  |  |  |
| BAAF Form PH (father) |  |  |  |
| BAAF Form (consent) |  |  |  |
| Child Permanency Report (CPR) |  |  |  |
| Social Work Chronology |  |  |  |
| Midwifery Information |  |  |  |
| Health Visitor Information |  |  |  |
| Red Book |  |  |  |
| Hospital Records (from other hospitals) |  |  |  |
| GP Records |  |  |  |
| Other reports / information provided (please list) |  |  |  |

**Relevant information:**

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| Summary of reasons regarding why an adoption medical is being sought for this child/young person. Please give a brief overview of the child’s journey, to include periods being on a Child Protection Plan and being looked after outside their parent’s care. |
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| Summary of any health, developmental, learning, mental health, or substance misuse difficulties/needs for the child’s mother and father. This information is key if we do not have access to completed BAAF Form PH regarding parental health. Please utilise information any historical records and/or expert assessments completed within proceedings. |
|  |
| Summary of any health, developmental, learning, mental health or any other relevant health/medical needs in relation to any sibling/half sibling(s) of this child. Please include information regarding any sibling(s) who may have been adopted or placed outside of the care of birth parents. |
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| Summary of any known health, developmental, learning, mental health, or substance misuse difficulties/needs of any other extended family member. |
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| **Signature of Social Worker** |  |
| **Name (in print)** |  |
| **Date** |  |
| **Email** **Telephone** |  |