|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Background pattern  Description automatically generated with medium confidence  **Reunification Referral Form** | | | | |  |
| This referral form is to refer a child, or sibling group, to the Reunification team for reunification support. The referral can only be made after the social worker has completed a Reunification Assessment which has been approved by their Team Manager.  When making this referral the Social Worker must also inform the child’s IRO, Virtual School, Children’s Commissioning and the Contact Service of the intention for the child to be reunified.  If there are specific housing needs relating to the plan, early involvement of Housing services is essential.  A *Looked After* Review is required to endorse the change to the child’s Care Plan to one of Reunification. This should be convened as soon as the decision is made that the child and family should receive reunification support.  Email your completed referral to: reunificationteam@bcpcouncil.gov.uk. | | | | | |
| **Date of referral** | |  | | | |
| **SW Name, Team and Team Manager** | |  | | | |
| **Child’s name / sibling group and Mosaic ID (provide details for all siblings being considered for reunification)** | |  | | | |
| **Please confirm that the following details are up to date on the child’s Mosaic record:** | | | | | |
| **Child’s current placement address and placement type** | | | | **Y / N** | |
| **Child’s legal status** | | | | **Y / N** | |
| **Child’s family relationships, including siblings and wider family network, and their contact details** | | | | **Y / N** | |
| **Child’s foster carer relationships and their contact details** | | | | **Y / N** | |
| **Child’s education setting** | | | | **Y / N** | |
| **Please confirm that the following documents are recorded and clearly labelled in the child’s Mosaic documents:** | | | | | |
| **Reunification Identification Tool** | | | | **Y / N** | |
| **Reunification Assessment** | | | | **Y / N** | |
| **Genogram** | | | | **Y / N** | |
| **Ecomap** | | | | **Y / N** | |
| **Impact Chronology** | | | | **Y / N** | |
| **Please list any other documents it would be helpful for the Reunification team to read as part of this referral (for example, evidence of the child’s voice, direct work, family time observations of note, any other relevant multi-disciplinary assessments) *Please ensure these are recorded and clearly labelled on Mosaic*** | | | | | |
|  | | | | | |
| **Other professionals supporting the child(ren) and relevant adults** | | | | | |
| **Agency, Role and Name** | **Contact Details** | | **Who are they supporting?** | | |
|  |  | |  | | |
|  |  | |  | | |
|  |  | |  | | |
|  |  | |  | | |
|  |  | |  | | |
|  |  | |  | | |
|  |  | |  | | |
|  |  | |  | | |
| **Is there any other information the Reunification team needs to know at this stage?** | | | | | |
|  | | | | | |