**JOINT RESOURCES ALLOCATION PANEL**

**JRAP REFERRAL ALERT (1)**

**Child / Young Person’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| *Forename* | *Surname* | *Gender* | *Date Of Birth* |
|       |       |  |       |

|  |  |  |
| --- | --- | --- |
| *Child / Young Person’s Home Address (including post code)* |  | *Child / Young Person’s Placement Address (including post code)* |
|       |  |       |

**Parent / Carer Details**

|  |  |  |
| --- | --- | --- |
| *Full Name* |  | *Address (including postcode)* |
|       |  |       |

|  |  |  |
| --- | --- | --- |
| *Direct Line* |  | *Relationship to Child* |
|       |  |       |

|  |  |  |  |
| --- | --- | --- | --- |
| *Referrer*  | *Role* | *Organisation* | *Email Address* |
|       |        |  |       |

|  |  |  |
| --- | --- | --- |
| *Address* | *Direct Line* | *Date Referral Sent* |
|       |       |       |

**Legal Status**

|  |
| --- |
| *Health* |
| *Is or have the child / young person subject to section under the Mental Health Act?* | Y [ ]  | N [ ]  |

|  |
| --- |
| *Social Care*  |
| *Date the child / young person became Looked After* |       |
| *Legal Status* |  |

|  |
| --- |
| *Education**(Date of EHCP)* |
|       |

**Reason for referral**

|  |
| --- |
| *Please describe primary needs*  |
|       |

|  |
| --- |
| *What is being requested?**Prior to JRAP, Health will need to investigate:**Children who need assessment**Children who have already had an assessment* |
|       |

|  |
| --- |
| *Consent* |
| *Has this referral been discussed with the child / young person / parent(s) and they consent to the referral and sharing of information?**(Evidence will be required)*  | Y [ ]  | N [ ]  |

**Social Care**

|  |  |  |
| --- | --- | --- |
| *Social Worker* | *Address* | *Team* |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| *Manager* | *Email Address* | *Direct Line* |
|       |       |       |

**Health**

|  |  |  |  |
| --- | --- | --- | --- |
| *Health Lead*  | *Role* | *Address* | *Team* |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| *Manager* | *Email Address* | *Direct Line* |
|       |       |       |

|  |  |  |
| --- | --- | --- |
| *CCG*  |  | *Registered GP* |
|  |  |       |

**Education**

|  |  |  |  |
| --- | --- | --- | --- |
| *EHC / SEN Lead* | *Role* | *Address* | *Team* |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| *Manager* | *Email Address* | *Direct Line* |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| *School Attended*  |  | *EHC Plan* |
|       |  | Y [ ]  N [ ]  |

**Once completed please send this referral to: generic health e mail boxes and include workers as above in the form in order that they are informed of the request and can respond to the referral.**

**Health have to complete their assessment within 28 days. If this time frame is not adhered to health will need to propose a new end date. If there is a delay of over the statutory 28 days all parties to be informed. If there is no reasonable explanation, the matter will be escalated to AD/AO.**

**This is part 1 of the JRAP referral please e mail to the JRAP administrator** admin.jrap@kent.gov.uk **once completed who will link professionals who will form the professional assessment network.**

**When submitting to panel please complete and submit parts 1 and 2 for panel.**