



Warwickshire MASH

Multi-Agency Referral Form (MARF)- Concerns about a Child

This form should always be completed when making a referral about a child/ren to the Warwickshire Multi-Agency Safeguarding Hub (MASH).

All urgent child protection referrals where there is an immediate concern about a child should be made by telephone by calling the MASH on telephone number 01926 414144. Outside of office hours for an immediate concern about a child in danger dial 999 and contact the Emergency Duty Team on telephone number 01926 886922.

1. Declaration

I hereby certify that the following information is accurate, reflects my concerns and is completed to the best of my knowledge to ensure that children are appropriately safeguarded

Yes ☐

2. About the Child

First Name	Enter the child's first name	Last Name	Enter the child's last name
Address	Click here to enter the address	Postcode	Click here to enter the postcode
Telephone	Enter the child's mobile number	Gender	Select a gender
Date of Birth or Expected Delivery Date	DD-MM-YYYY	If you do not know this information, estimate the child's age	Enter estimate age
Ethnicity	Choose a category	Religion	Choose a category
Disability	Please choose	Please state (see guidance for definitions)	Choose the disability which best corresponds with the child's needs
Interpreter Required? (If yes, state language)		Yes <input type="checkbox"/> No <input type="checkbox"/> Which language?	
Defining physical features e.g. hair colour, eyes		Please describe the child's appearance	
Residential Status		Owner/Occupier	
Priority Family		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Housing Association who is the landlord		Choose a category	

3. Other children cause for concern in the same family (please insert row if you require space for more people – right click and insert below)

First Name	Last Name	DOB/EDD/Age	Ethnicity	Address and Telephone	Gender	Relationship to the Child	School or GP if different to Child
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text

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4. About You			
First Name	Click here to enter your name	Last Name	Click here to enter your name
Name of Organisation	Enter your organisation	Job Title	Click here to enter your role
Email Address	Enter your email address	Telephone Number	Enter your contact number
Relationship to child / your agency's role or service provided	How do you know the child?	Contact Address	Enter your work address

5. Parent or Carer Informed	
✓ As a referrer working with the child or family, it is your responsibility to speak to the parents or carers about your concerns; unless by doing so will place the child at risk of significant harm.	
What level of discussion have you held with the parents?	Choose an item
The reason I have not spoken to the child's parents and carers/ have not gained consent is...Enter text	

6. Reason for Concern (If your concern is about an Adult we still need you to complete this section)	
Why are you concerned about the child?	Click here to enter text
What has prompted you to make a referral today?	Click here to enter text
Was anyone else present?	Click here to enter text
When did this happen?	Click here to enter a date Click here to enter a time
Where is the child at the point of referral submission?	Click here to enter text
What has the child said or experienced?	Click here to enter text
When did you last see the child/ family?	Click here to enter text
Is there indication of physical harm to the child?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Is there suspected...	
Sexual Abuse?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Alcohol or Substance Abuse?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Mental Ill Health?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Emotional Abuse or Self-Harm?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Neglect?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Domestic Abuse?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Child Sexual Exploitation?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Trafficking?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Female Genital Mutilation (FGM)?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Forced Marriage?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Honour Based Violence?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Extremism?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Is the child missing from home, school or view?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Does the child or family have a legal right to be living in the UK?	Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please describe
What action have you / your agency taken to address this specific concern?	Click here to enter text
Confirm how long you have been involved; include any historic concerns and action taken	Click here to enter text

7. The Child's Voice	
I have spoken to the child about my concerns and they are aware of this referral	Please choose
The reason I have not spoken to the child about my concerns is....Click here to enter text	

OFFICIAL/SENSITIVE UPON COMPLETION

8. Details of Father / Mother / Siblings / Carers / Family Members / Significant Adults i.e. the perpetrator (please insert row if you require space for more people – right click and insert)							
First Name	Last Name	DOB/EDD /Age	Ethnicity	Address and Telephone	Gender	Relationship to the Child	School or GP if different to Child
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text
First Name	Last Name	Include	Choose	Insert Details	Select	Please state	Enter text
Please state who has parental responsibility					Please provide name(s)		
Does any member of the family require an interpreter or an alternative method of communication (e.g. sign language)? If so what language or type of support is required and for who?					Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details		
Does your referral relate to any other children or young people?					Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details		

9. Details of Professionals Involved with Child or Family (including GP, School, Health worker, CAF worker)			
Name	Organisation	Relationship to Child	Address and telephone number
Insert Name	Insert Name	Insert Text	Insert Telephone Number and Address
Insert Name	Insert Name	Insert Text	Insert Telephone Number and Address
Insert Name	Insert Name	Insert Text	Insert Telephone Number and Address
Insert Name	Insert Name	Insert Text	Insert Telephone Number and Address
Has a CAF already been completed? (Please attach or provide contact details)			Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who is the lead professional?
Have you discussed this already with a MASH Officer?			Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who did you speak with?

10. What kind of referral are you making to the MASH	
Are you making a Child Protection referral as you are concerned this child is at immediate risk of harm?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you making a Child In Need referral as you are not concerned about the child being at immediate risk of harm?	Yes <input type="checkbox"/> No <input type="checkbox"/>

10. Date & Time referral has been sent to MASH	
Date of referral:	Click here to enter a date.
Time of referral:	Click here to enter a date.

If you have concerns about immediate significant harm of a child Act Without Delay.

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If you telephone the MASH as you have an immediate concern for a child's safety, you must then complete the Multi Agency Referral Form – MARF as written confirmation of your referral. This should be completed and sent to the MASH on the same day. If you have made your telephone referral to the Emergency Duty Team, please still complete the Multi Agency Referral Form – MARF as written confirmation of your referral.

Upon completion of the MARF please email the referral from a secure email address and send to the MASH at mash@warwickshire.gcsx.gov.uk or complete the form online. The MASH has no fax facilities. If you are having difficulties sending your referral please call the MASH on 01926 414144.

Remember to send any other relevant documents with the MARF, such as copies of a CAF if this has been completed or other documents which may evidence concerns or detail previous action/concerns that your agency has undertaken.

The MASH should acknowledge your referral within 24 hours of receipt. If you have not heard back within 2 working days, contact the MASH.

After sending this referral to the MASH please maintain a copy of this form on the child's record or in your agency file and ensure you record when the referral was sent and when you receive an acknowledgement from the MASH. If you work in Education or Health please also send another copy of the referral to your agency safeguarding lead for monitoring purposes.

For further information please refer to the Warwickshire Safeguarding Children's Boards Procedures available at www.warwickshire.gov.uk/wscb and the MASH Standard Operating Procedures available at www.warwickshiremash.org