

**Specialist Community Public Health Nursing/Family Nurse Safeguarding Children Summary Transfer Template**

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|  | **Family Details/Composition/Network** | | | | | | | |
| **Name of Child** | | **DoB/**  **EDD for unborn baby** | **HCN** | **Disability** | **Child in need** | **Child protection Register** | **Category**  **of Registration** | **LAC/**  **Legal status** |
|  | | Click or tap to enter a date. |  | Y  N | Y  N | Y  N |  | Choose an item. |
|  | | Click or tap to enter a date. |  | Y  N | Y  N | Y  N |  | Choose an item. |
|  | | Click or tap to enter a date. |  | Y  N | Y  N | Y  N |  | Choose an item. |
|  | | Click or tap to enter a date. |  | Y  N | Y  N | Y  N |  | Choose an item. |

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| **Address** | |
| Previous: | New: |
| Telephone: | Telephone: |
| Telephone: | Telephone: |
| **Person with Legal Parental Responsibility** | |
| Name: | Name: |
| DOB: | DOB: |
| Relationship: | Relationship: |
| Address: | Address: |
| Telephone: | Telephone: |
| **Significant Other Family/Friends** | |
| Name: | Name: |
| DOB: | DOB: |
| Relationship: | Relationship: |
| Address: | Address: |
| Telephone: | Telephone: |
| **Foster Carers** | |
| Name: | Name: |
| DOB: | DOB: |
| Relationship (if kinship): | Relationship (if kinship): |
| Address: | Address: |
| Telephone: | Telephone: |
| Are foster carers details confidential and not to be shared with the family? Yes No | |
| Not applicable: | |

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| **Background** |
| ***Prompt- remove on completion:***  *General background information. Brief description of what led to current situation.* |
| **What is working well- summary?** |
| ***Prompt- remove on completion:***  *Refer to Signs of safety record keeping/report writing guidance. If a SCPHN/FN report has been written for any LAC/safeguarding /family support meeting within the last 3 months- attach report and make reference here ie ‘[name of meeting] report attached’* |
| **What are we worried about- summary?** |
| ***Prompt- remove on completion:***  *Refer to Signs of safety record keeping/report writing guidance. If a SCPHN/FN report has been written for any LAC/safeguarding /family support meeting within the last 3 months- attach report and make reference here ie ‘[name of meeting] report attached’ or ‘as above’’*  *Include past harm and complicating factors* |
| **What needs to happen- summary?** |
| ***Prompt- remove on completion:***  *Refer to Signs of safety record keeping/report writing guidance. If a SCPHN/FN report has been written for any LAC/safeguarding /family support meeting within the last 3 months- attach report and make reference here ie ‘[name of meeting] report attached’ or ‘as above’’* |

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| **Safeguarding Meeting (strategy / core group / case conference / LAC review)** | | |
| Date of last meeting: | | |
| Date of next meeting: | | |
| Not applicable: | | |
| **Social Work Case Coordinator** | | |
| **Previous** | **New if known** | |
| Name: | Name: | |
| Designation: | Designation: | |
| Base: | Base: | |
| Telephone/Email: | Telephone/Email: | |
| Date discussed: | Date discussed: | |
| Not applicable: | Not applicable: | |
| **Other professional network** | | |
| Name: **Prompt-remove on completion:** include GP | Name: | |
| Designation: | Designation: | |
| Base: | Base: | |
| Telephone: | Telephone: | |
| **Other professional network** | | |
| Name: | Name: | |
| Designation: | Designation: | |
| Base: | Base: | |
| Telephone: | Telephone: | |
| **Handover** | | |
| Name of receiving SCPHN/Family Nurse/ROI Public Health Nurse: | | |
| Designation of receiving SCPHN/Family Nurse/ROI Public Health Nurse: | | |
| Base: | | Telephone/Email: |
| Date of verbal handover: | | |
| Date of Safeguarding Children Summary Sheet Transfer Template forwarded: | | |
| Copies of written/electronic records:   * Child health record Y  N * Family Health Assessment Y  N * Chronology of significant events Y  N * Minutes of meetings Y  N   **Or**   * Available on request   Comments: | | |
| Date child health records returned to local Northern Ireland Child Health Office: | | |
| Contact details of local Child Health Office: | | |
| Date CHS8 completed: | | |
| Current SCPHN/Family Nurse | | |
| Name: | | Designation: |
| Base: | | Telephone/email: |
| Signature | | Date: |