

HOME-START DACORUM
 The Gables, 3 St. Mary's Road
 Hemel Hempstead, Herts HP2 5HL
 Tel: 01442 254499 Fax: 01442 248319



REFERRAL FORM

Children's Centre:

MON No.

DATE OF REFERRAL

STAT No.

DATE RECEIVED

WE ARE UNABLE TO PROCESS YOUR REFERRAL UNTIL WE RECEIVE THIS FORM.

Please note that all referrals must be made with the consent of the family. Have you discussed this referral with the family prior to completing this form? **YES / NO**

This form will be held in confidence, but may be shown to the family if requested. Please note that the family must have at least one child under the age of five years.

NAME OF FAMILY:.....

ADDRESS:.....

..... Postcode..... Tel.....

EMAIL ADDRESS..... Mobile.....

NAME OF MOTHER:..... SINGLE PARENT: YES / NO D.O.B...../...../.....

NAME OF FATHER/PARTNER:..... D.O.B...../...../.....

NAME OF CHILD	MALE / FEMALE	DATE OF BIRTH	REGISTERED DISABLED	C.P. REGISTER	CONCERN FOR CHILD/CP INVESTIGATION

<p>Referred By: (please give <u>FULL</u> details)</p> <p>Name:..... Self / Other.....</p> <p>Agency.....</p> <p>Address:.....</p> <p>.....</p> <p>Tel No.....</p> <p>Email.....</p>	<p>Family Doctor.....</p> <p>Tel No:.....</p> <p>Health Visitor.....</p> <p>Tel No:.....</p> <p>Other Agencies Involved.....</p> <p>.....</p> <p>.....</p>
--	--

Ethnicity of Main Carer:

Indian		Caribbean		British	
Pakistani		African		Irish	
Bangladeshi		Any other Black background, please specify:		Any other background, please specify:	
Chinese					
Any other Asian background, please specify:		Any Mixed background, please specify:			

So that we can offer the family the most appropriate support, and match the most suitable volunteer, please complete the following table. Please note that there is not a 'points' system. Families will not be prioritised on the basis of how many categories are ticked.

This information also helps us to evaluate the outcomes of our support.

I hope that Home-Start will help meet the needs the family has in the following areas:

Please Tick ✓		
	1.	Feeling isolated
	2.	Using other services / facilities in the area
	3.	Parent (s) emotional health / well-being
	4.	Parent (s) self-esteem
	5.	Parent (s) physical health / well-being
	6.	Child (ren's) physical health / well-being
	7.	Child (ren's) emotional health / well-being
	8.	Managing the child (ren's) behaviour

Please Tick ✓		
	9.	Being involved in the child (ren's) development
	10.	Stress caused by conflict in the family
	11.	The day to day running of the house
	12.	Managing the household budget
	13.	Coping with the extra work caused by multiple birth / multiple children under 5
	14.	Depression / PND
	15.	Family Group Only
	16.	Other (please describe)

Why have you made this referral?

Please identify three specific outcomes you would like to see achieved:

- 1.....
- 2.....
- 3.....

In what time scale?

Risk Assessment

Please tell us about any Health & Safety issues that we need to consider when placing a volunteer with this family.

Please add any background information that you think we would find useful, eg do you know if there is a CAF in place? If so, who is the lead professional? *(If necessary, attach an extra sheet).*