**TOGETHER@FACES**

*OFFICE USE ONLY* – **FAMILY NUMBER**

**REFERRAL FORM**

*Please complete* ***all*** *sections or your referral may be returned.*

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| If this referral is being made on behalf of a family, it must be made with the consent of the family and **we cannot proceed without this***Please tick to confirm parent(s)’ consent and complete signature boxes overleaf 🖵*  |

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| **Information about the parents/carers involved with the child(ren)** |
| **Name of Family:** |
| **Address (inc post code):** | **All telephone numbers:** |
| **Relationship to Child(ren)** |  | **Main Carer √** | **Parental****Responsibility √** | **Resident in family home √** |
| **Mother/Partner****Name** |  |  |  |  |
| Date of Birth |  |  |  |  |
| Ethnic Origin |  |  |  |  |
| **Father/Partner****Name** |  |  |  |  |
| Date of Birth |  |  |  |  |
| Ethnic Origin |  |  |  |  |
| **Other Main Carer****Name** |  |  |  |  |
| Date of Birth |  |  |  |  |
| Ethnic Origin |  |  |  |  |

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| **Referrer Information** |
| **Referrer Name:** | **Address (inc postcode)** |
| **Agency:** | **Email:** |
| **Role:** | **Tel:**  |
| **Other Agencies Working with the Family *(inc nursery and schools)*** |
| **Family Doctor Name:****Surgery Address:****Tel:** | **School/Nursery Staff Member:****School/Nursery:****Tel:****Email:** |
| **Health Visitor:****Tel:** **Email:**  | **Name/Role:****Agency:****Tel:****Email:** |

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| ***Why are you referring the family to FACES?*** ***Please also specify Family Need overleaf*** |
| ***Have you discussed this referral with parents?*** |
| ***Does the family give us permission to contact other agencies with a view to supporting them?***  |
| ***Are there any Health and Safety issues we need to consider? Y/N – if YES, please provide details.***  |

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| **Issues Present in Current Situation (please √ all that apply)** |
| Lone Parent | Substance Abuse  | Domestic Abuse  | Mental Health Issues | Learning Disability | Physical Disability | Post Natal Depression  | Interpreter Needed | Teen Pregnancy  |
|  **Support Services Requested** **(please √ all that apply and use relevant referral form)** |
| Together@FACESGeneric home visiting service for parents with children 0-19 | Domestic Abuse Use BDASS referral form | BabyFACES plusTargeted support to prevent adverse childhood experiences | Children and Young People’s project  | Family Group | Other inc crisis funding and CSE |

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| **Information about the Child(ren)** |
| **No.** | **Name** | **DOB** | **Gender****(M/F)** | **Ethnic Origin** **(please state)** |
| **C1** |  |  |  |  |
| **C2** |  |  |  |  |
| **C3** |  |  |  |  |
| **C4** |  |  |  |  |
| **C5** |  |  |  |  |
| **C6** |  |  |  |  |

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| **Information about any Plans Family are Subject to** |
| **Child****No.**  | **CAF/EHA (Y/N)** | **TAF/TAC****(Y/N)** | **CIN** **(Y/N)** |  **CP** **(Y/N)** | **Name and contact details of Lead Professional (if applicable)** |
| **C1** |  |  |  |  |  |
| **C2** |  |  |  |  |  |
| **C3** |  |  |  |  |  |
| **C4** |  |  |  |  |  |
| **C5** |  |  |  |  |  |
| **C6** |  |  |  |  |  |

***Family needs –*** *In order that we can offer the best support, please complete the following table indicating why a family need help in meeting their children’s needs in the areas stated.*

*This information, together with that gathered at initial assessment (which will take place after completed referral form received) and serves to inform our tailored plan of support.*

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| --- | --- | --- |
| **Family Need** | **√** | **If ticked, please state why this is a need** |
| Physical Health |  |  |
| Emotional Wellbeing |  |  |
| Resolving Conflict in the Family |  |  |
| Keeping the child(ren) safe |  |  |
| Social Networks |  |  |
| Issues with Education & Learning/Child Development |  |  |
| Managing Routines/ Boundaries & Behaviour |  |  |
| Issues with Home and Money |  |  |

We cannot proceed with support until we have received this completed referral form (*which needs to be completed within one calendar month from date of issue*). We will try to respond to you within two weeks to let you know about progress of this referral.

* **Self referrals** – Our family support practitioners will be in touch to arrange an initial assessment with you at your home where they will discuss with you how best we can support you.
* **Professionals -** we will remain in touch whilst we support this family and will let you know when support ends.

***We cannot proceed without parent’s consent so please ensure parent(s) sign below. If verbal consent given, please state this below.***

|  |  |
| --- | --- |
| Parent’s Signature: | Date: |
| Referrer’s Signature:(if applicable) | Date: |