**HOME-START NEA REFERRAL FORM Date received…………….**

* **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**
* **The family must have at least one child under the age of five years.**

**Name of family**………………………………………

Address……………………………………………………………………………………………………………

………………………………………………………………Postcode …………………………………………

Main contact Number …………………..………E mail ………………………………

**Please provide some details about the adults caring for the child[ren] who currently live in the household:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Name | Date of Birth | Gender  M/F | Disability  Y/N | CP register  Y/N |
| Main Carer |  |  |  |  |  |
| Spouse/partner |  |  |  |  |  |
| Childs name |  |  |  |  |  |
| Childs name |  |  |  |  |  |
| Childs name |  |  |  |  |  |
| Childs name |  |  |  |  |  |
| Childs name |  |  |  |  |  |

**Has the family received support from Home-Start previously? Yes No When did it end……………………………**

**Housing Type**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Unknown | Temp Housing | Overcrowding | Privately owned | Privately rented | Social Housing |
|  |  |  |  |  |  |

**Transport**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Unknown | With car | Without car | Public transport route | No public transport | Public transport difficult |
|  |  |  |  |  |  |

**Referred by: Date of referral:**

|  |  |
| --- | --- |
| Name  Role  Agency  Address  E mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Postcode  Tel | Family Doctor  Tel  Health Visitor  Tel  E mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other agencies involved |

**Please √ all that apply to this family**: This is purely statistical information primarily for future funding applications.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Lone parent | substance abuse | domestic abuse | mental health issues | learning disabilities | post natal depression | interpreter required | teenage pregnancy 19yrs or younger | other please specify |
|  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Immigration Status, Asylum seeker or Refugee | Asian and Asian British | Black or Black British | Chinese or Chinese British | Mixed Race | White or White British |
|  |  |  |  |  |  |

**Are there any Health and Safety issues that we need to consider when placing a volunteer with this family:**

………………………………………………………………………………………………………………………………………………………………………..

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**Please add any background information that you think we would find useful (if necessary attach an extra sheet)**……………………………………………………………………………………………………………………………………………………………

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**Family needs -** 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, together with information provided by the family,

will be used to monitor how our support meets the family’s needs. I hope that Home-Start will help meet needs the family has in the following areas:

|  |  |  |
| --- | --- | --- |
| **Family Needs** | **√** | **If you have ticked, please tell us why this is a need** |
| Managing child’s behaviour |  |  |
| Being involved in the child(ren)’s development |  |  |
| Coping with own physical health |  |  |
| Coping with own mental health |  |  |
| Coping with feeling isolated |  |  |
| Parent’s self-esteem |  |  |
| Coping with child’s physical health |  |  |
| Coping with child’s mental health |  |  |
| Managing the household budget |  |  |
| The day-to-day running of the house |  |  |
| Stress caused by conflict in the family |  |  |
| Coping with multiple birth/multiple children under 5 |  |  |
| Use of services |  |  |
| Other (please describe) |  |  |

Referrers signature ……………………………………………. Date ………………………………..

Parent’s signature …………………………………………. Date ………………………………… ..

Thank you for taking time to provide this information which will help us to process the referral.

We are unable to process your referral until we have received this form and the family have signed it.

We will let you know when we have completed an initial visit with the family and when we introduce a volunteer. We will also contact you when support has ended.

If you have any issues or concerns about the referral process or the support for the family, please contact

**Melinda Stewart 01346 532007 or E-mail office@home-startnea.org.uk Please email and reduce waste**