HOME-START REFERRAL FORM

(Office use only)	
Home-Start Family ID No:	*Logged on Referrals sheet* ☐

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.
We try to respond to all referrers within 2 weeks after receiving the referral to report progress.
If you have any issues or concerns about the referral process or the support for the family, please contact Jo Johnston, Senior Coordinator.

Name of Family: _____ ***Date:*** _____

Address: _____

_____ Post Code: _____

Tel: _____ Mobile: _____

E-mail: _____

Please provide some details about the adults caring for the child[ren]:

NAME	M / F	Main Carer ✓	Relationship to child (if applicable)	Resident in household ✓	Date of Birth	Do they consider themselves disabled? Y / N *(Give details overleaf)*	Ethnicity *(see below*)*
Mother / Partner:							
Father / Partner:							
Other Main Carer(s):							

Please provide some details about the children (include details of all children under 18)

NAME of Child/ren	M / F	Date of Birth	Considered to be disabled by main carer? ✓ *(Give details overleaf)*	CPP ✓	Child in Need ✓	Looked after Child ✓	Other Social Care ✓	Ethnicity *(see below*)*

**** ETHNICITY (Please use abbreviations below)***

ASIAN OR ASIAN BRITISH Indian (**AI**) Pakistani (**AP**) Bangladeshi (**AB**) Other Asian (**OA**)	BLACK OR BLACK BRITISH Caribbean (**BC**) African (**BA**) Other (**OB**)	CHINESE (**C**)	ANY MIXED (**M**)	OTHER ETHNIC GROUP (**OE**)	WHITE British (**WB**) Irish (**WI**) Other White (**OW**)

Referred by:	**Family Doctor** _____
Name _____ Self * _____	Tel _____
Agency_____	**Health Visitor** _____
Address _____	Tel _____
_____	**Other Agencies involved**
_____	_____
Tel _____	_____

Please tell us if an interpreter is required for this family *YES / NO*

* If **Self-Referral** – "How did you hear about Home-Start?"

Friend/Family/Neighbour ☐ Health Visitor ☐ Social Worker ☐ Other ☐

Permission given to speak to another professional supporting the family, eg Health Visitor *YES / NO*

Support Required ***(please tick the project most appropriate for the family's needs)***

☐ **FAMILY KNOW-HOW PROJECT**
Practical and emotional family support

- fortnightly Family Groups (Lutterworth/Market Harborough)
- volunteer support in the home
- 6-week course – healthy lifestyles
- counselling

☐ **FAMILY PNI PROJECT**
Help for families affected by Post-Natal Illness

- fortnightly PNI Groups (Market Harborough/Broughton Astley)
- volunteer support in the home
- 6-week course for post-natal illness
- Counselling

☐ **YOUNG PARENTS PROJECT**
for parents < 21 years

The appropriate services will be identified by a Home-Start Family Coordinator at Initial Visit stage.

Additional Information

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

Disability (tick if applicable Parent ☐ Child ☐

Physical Illness (tick if applicable) Parent ☐ Child ☐

If TICKED, please give details:

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 no 'points' system – families will not be prioritised on the basis of how many categories you have 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:

		✓	*If you have ticked, please tell us why this is a need*
1	**Managing child's behaviour**		
2	**Being involved in the child(ren)'s development**		
3	**Coping with own physical health**		
4	**Coping with own mental health**		
5	**Coping with feeling isolated**		
6	**Parent's self-esteem**		
7	**Coping with child's physical health**		
8	**Coping with child's mental health**		
9	**Managing the household budget**		
10	**The day-to-day running of the house**		
11	**Stress caused by conflict in the family**		
12	**Coping with the extra work caused by multiple birth/multiple children under 5**		
13	**Use of services**		
14	**Other (please describe)**		
15	**Parents' own learning needs**		

Please tick all boxes relevant to this family's situation:

Lone parent	☐	Teenage mother	☐	Workless household	☐
Parental conflict	☐	Migrant / Asylum seeker family	☐	Family of offender	☐
Parent with learning Difficulties	☐	Drug/alcohol issue in household	☐	Family in temporary accommodation	☐
Multiple birth	☐	Domestic abuse in household	☐	Traveller family	☐
Post-Natal Illness	☐	Other Mental Health	☐	LGBT	☐

Are there any HEALTH AND SAFETY ISSUES that we need to consider when placing a volunteer with this family (eg domestic violence, substance abuse)

YES ☐ **NO** ☐

If YES, please give details:-

Have you visited the family in the home? YES / NO

Referrer's Signature : ..... **Date:** .....

Main Carer's Signature (*optional*) : ..... **Date:** .....

Thank you for taking time to provide this information which will help us to process the referral.
We will try to respond to you within two weeks from receipt to tell you about progress with this referral.

RETURN COMPLETED FORMS TO:

Home-Start South Leicestershire
121 Coventry Road
Market Harborough
Leics
LE16 9BY

Tel: 01858 467982
Fax: 01858 468177