

HOME-START REFERRAL FORM



(Office use only) Home-Start Family ID No: _____	Entered on Yellow Stats Sheet <input type="checkbox"/>
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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. The family must have at least one child under the age of five years.

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 Karen Hulett, Scheme Manager.

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)
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Referred by:
 Name _____ Self * _____
 Agency _____
 Address _____

 Tel _____

Family Doctor _____
 Tel _____
Health Visitor _____
 Tel _____
Other Agencies involved

* If Self-Referral - "How did you hear about Home-Start?"
 Friend/Family/Neighbour Health Visitor Social Worker Other
 Please tell us if an interpreter is required for this family YES / NO

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

- FAMILY KNOW-HOW PROJECT**
 (practical family support)
- present Family Groups (Lutterworth/Market Harborough)
 - volunteer support in the home
 - 6-week course - healthy lifestyles
 - counselling

- FAMILIES IN MIND (FIMs)**
 (emotional family support)
- fortnightly peer support group (Market Harborough/Broughton Astley)
 - 6-week course for mild-moderate levels of depression, anxiety, stress
 - volunteer support in the home
 - counselling

- FAMILY KNOW-HOW (RELATIONSHIPS)**
- 5-7 yrs Play Sessions

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:

		✓	<i>If you have ticked, please tell us why this is a need</i>
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)		

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

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

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: _____
Parent'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**