Family Friends Referral

|  |  |  |  |
| --- | --- | --- | --- |
| For office use only:Date referral received: |       |  |  |
|  |  |  |  |
| Proposed service:(Please tick) | Volunteer Support [ ]  | Children’s Group(Anxiety, SCWAD) [ ]  | Army Family Support [ ]  |

Checklist:

Does the family live in RBWM?  [ ]

Is the family/child in agreement with the referral?  [ ]

Does the referrer consider this referral is in keeping with early help? [ ]

Do the family have at least one child aged 0-13? [ ]

If no to any of these then the referral cannot proceed.

|  |  |  |
| --- | --- | --- |
| **Repeat referral?** | No [ ]  Yes [ ]  | If yes, details:       |

**Carers/Parents Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title** | **First Names** | **Surname** | Primary Contact Tel Nos: | Relationship to Child | Ethnicity |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |

**Address Detail:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Address 1** | **Address 2** | **Town**  | **Post Code** | Email |
|       |       |       |       |       |

**Child/Childrens’ Details:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Surname(s)** | **First Name(s)** | **M / F** | DOB | School  | Year | SEND | EHCP | Ethnicity |
|       |       |       |       |       |       | [ ]  | [ ]  |       |
|       |       |       |       |       |       | [ ]  | [ ]  |       |
|       |       |       |       |       |       | [ ]  | [ ]  |       |
|       |       |       |       |       |       | [ ]  | [ ]  |       |
|       |       |       |       |       |       | [ ]  | [ ]  |       |
|       |       |       |       |       |       | [ ]  | [ ]  |       |
|  |
| **GP Practice where family are registered** | **Name of Health Visitor: (if family has one)** |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referrer** | **Agency** | **Telephone** | **Email** | **Where did you hear about FF?** |
|       |       |       |       |       |

|  |
| --- |
| **Reason for Referral: (Please provide as much detail as possible. If an EHP exists, please attach)**      |

**Outcomes the family are looking for:**

|  |
| --- |
| *
*
*
 |

|  |  |  |
| --- | --- | --- |
| **Any other agencies already involved with the family?** | **Yes** [ ]  **No [ ]**  | **If yes, please list details below:**  |
| **Name** | **Organisation** | **Tel No or Email:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Any Social Care involvement with the family (either present or historic)?** | **Yes [ ]** **No [ ]**  | **If yes, please provide full details:** |
| **Current concerns and risks for the family?** | **Yes [ ]** **No [ ]**  | **If yes, please provide full details:**  |
| **Any known risk factors or safety concerns for visitors?****(ie. Domestic abuse, anti-social behaviour, pets etc)** | **Yes [ ]** **No [ ]**  | **If yes, please provide details:**       |
| **Please ‘x’ all that apply to the family:** |
| Single Parent | **[ ]**  | Domestic Abuse - current | [ ]  | Domestic Abuse - historic | [ ]  | Mental Health - adult | [ ]  | Mental Health - child | [ ]  |
| Disability – child | [ ]  | Disability – Adult | [ ]  | Child ASD/ADHD | [ ]  | Postnatal Depression | [ ]  | Finance/low income | [ ]  |
| Benefits | [ ]  | Multiple births | [ ]  | Multiple children >5 | [ ]  | Health/medical – child | [ ]  | Health/medical – adult | [ ]  |
| Divorce/separation | [ ]  | Parent under 25 | [ ]  | Children’s behaviour | [ ]  | Isolation | [ ]  | Stress | [ ]  |
| Army Family | **[ ]**  | Young Carer | [ ]  | Other | [ ]  | Please state:       |
|  |
| **Consent:****In compliance with GDPR, authorisation by the parent/carer must be given for the following:** | *Please tick* |
| They agree for the referral to be made. | [ ]  |
| They understand what personal data has been shared on this referral and that this will be stored securely, in our office and on our secure database, with only authorised persons having access to this. | [ ]  |
| Signature of Parent giving authorisation:**If signature cannot be obtained, referrer must state that verbal consent by the parent/carer has been given and the date this was given.** | Date:      |
| The parent/carer agrees that information already held by other agencies and information from this referral can be shared if necessary.**If there is evidence or reasonable cause to believe a child/young person is suffering, or at risk of suffering significant harm, practitioners have a legal responsibility to inform Children’s Social Care. In most cases, they will discuss this with you first.** | [ ]  |
| **Referrer’s Name:**      | Signature:      | Date:      |
| Please ensure that full information is provided. The form will be returned to you if there is insufficient information or if all fields are not completed. **Email to:** **info@family-friends.org.uk** If you have any queries, please contact Kerry Byde, Office Administrator on 0300 800 1005 |