****

*OFFICE USE ONLY* – **FAMILY NUMBER**

**UNIVERSAL 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**  **P***lease 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 |  | |  |  |  |

|  |  |
| --- | --- |
| **Referrer Information** | |
| **Referrer Name:** | **Address (inc postcode)** |
| **Agency:** | **Email:** |
| **Role:** | **Tel:** |
| **Other Agencies Working with the Family** | |
| **Family Doctor Name:**  **Surgery Address:**  **Tel:** | **Name/Role:**  **Agency:**  **Tel:**  **Email:** |
| **Health Visitor:**  **Tel:**  **Email:** | **Name/Role:**  **Agency:**  **Tel:**  **Email:** |
| ***Why are you referring the family to FACES?***  ***Please also specify Family Need overleaf*** | |
| ***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)** | | | | | | | | | | | |
| Domestic Abuse  Use BDASS referral form | | | Child Sexual Exploitation  *Use Changing FACES Referral Form and include CSE Risk Assessment (except for self referrals)* | | | | Children and Young People’s project | | | Family Group | |

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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) serves to inform our tailored plan of support.*

|  |  |  |
| --- | --- | --- |
| **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: |