HOME-START DEESIDE, ALFORD & STRATHDON 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	Family Doctor
Role	Tel
Agency	Health Visitor
Address	Tel
E mail _____	E mail _____
Postcode	Other agencies involved
Tel	

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:

……..

……..

……..

……

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

……

……

……

……

……

……

……

……

……

……

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

Leah Bruce: 07741554675. leah@homestartdeeside.org Please email and reduce waste