Enhanced New Beginnings Referral Form **Date Received** _____

Family No _____

Home Start
Support and friendship for families

Please circle which service(s) you would like the family to be referred for:

Home Visiting **Shepway Project Programmes*** **One Stop Shop**

**Freedom Programme, Power to Change, Recovery Toolkit, DAY Programme, Support Group.*
Home-Start Shepway will carry out an assessment with the family to identify which programmes are most suitable.

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**

Some points for consideration when you discuss the support with women:
Do not discuss in front of her partner or children.
Ensure that she understands that she should not tell anyone what the support is for – this is to protect her and others.

Name of Family _____

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

	Name	Main carer √	Resident in household √	Date of Birth	Comments
Mother/partner					
Father/partner					
Other main carer[s]					
Other main carer[s]					

Address……

…… Postcode ……

Tel. No…… Mobile No ……

Is it safe to contact the family by phone?	**Yes/No**
Is it safe to write to the family at this address?	**Yes/No**

Safe contact details if different from above ……

……

……

Is the perpetrator still living in the family home? **Yes/No**

Perpetrator's Name _____ Perpetrator's D O B _____

Has a MARAC been issued? **Yes/No** Dash Score & Date ……..

DVPO issued? **Yes/No** Date Until ……..

Please circle all other agencies involved:

Health Visitor Police IDVA Social Worker Supporting People School FLO Early Help Other

Does the mother (or her children) use alcohol or drugs in order to cope with the abuse? **Yes/No**

Has the mother ever been cautioned or charged with a criminal offence by the Police? **Yes/No**

Are there any Health and Safety issues that we need to consider when placing a volunteer?

_____
_____
_____

Have you visited the family **Yes/No**

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

_____
_____
_____

Referred by: **Date of referral:**

Name Role Agency Address E mail _____ Postcode Tel	Family Doctor Tel Health Visitor Tel E mail _____ Other agencies involved eg School, Health Visitor, Social Worker Name_____ Address (including Postcode)_____ _____ E Mail_____ Work No_____ Mobile No_____

Please √ all that apply to this family:

Lone parent	Substance abuse	Domestic abuse	Mental health issues	Learning disabilities	Post natal depression	Separating families support	Teenage pregnancy 19yrs or younger	Universal Credit	Other - please specify

Details of children - Please note the family must have at least one child under the age of eight years. Please include details of all children under 18.

Child's Name - oldest first	Gender		Date of birth	Immigration status			Considered to be disabled by main carer? √ if yes	Asian or Asian British				Black or Black British			Chinese or Other Ethnic Group		Mixed	White			Subject to assessment of needs e.g.Early Help (√) Please send a copy to us	Who is the lead professional?	Child in need √	Child care/ protection plan (√)
	Male	Female		Asylum seeker	Refugee	Pending		Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese	Other Ethnic	Any mixed	British	Irish	Other White				
C1.																								
C2.																								
C3.																								
C4.																								
C5.																								
C6.																								
C7.																								
C8																								
C9																								
C10.																								

Please complete those boxes which apply to any of the children

Note: the terms above are nation-specific - not all will be relevant in your area

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 self confidence		
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 (quality of life)		
Coping with multiple birth/multiple children under 5		
Use of other services		
Life skills - Shepway Project		
Parents own learning needs		

Details of members of the household with responsibilities for caring for the children

	Gender		Immigration status			Consider themselves to be disabled	Asian or Asian British				Black or Black British			Chinese or Other Ethnic Group		Mixed	White		
	Male	Female	Asylum seeker	Refugee	Pending	YES?	Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese	Other Ethnic	Any mixed	British	Irish	Other White
Main Carer																			
Partner living in household																			

	RELIGION OR BELIEF									SEXUAL ORIENTATION		
	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	Rather not say	Hetero sexual	Lesbian, gay man, bisexual	Rather not say
Main Carer												
Partner living in household												

All information on this form is treated with the strictest confidence and is only passed onto other agencies on a need to know basis. If issues arise that involve child protection, criminal or legal matters these will need to be passed onto the appropriate authority.

Referrer's signature …….. Date ……

Parent's signature …….. Date …… (optional)

Thank you for taking time to provide this information which will help us to process the referral.

Please return the completed form to:

Amanda Walker, Home-Start "Enhanced New Beginnings" Project Co-ordinator, 24 Cheriton Gardens, FOLKESTONE CT20 2AS

We will try to respond to you within two weeks to tell you about progress with this referral. We will remain in touch while supporting this family and will contact you when the support ends.

Please note that due to limited availability, we will not be able to offer places on the Shepway Project Programmes to all families immediately.

If you have any issues or concerns about the referral process or the support for the family, please contact the Enhanced New Beginnings Project on 01303 244836