Family No.: ………..……..
(Office use only)

Home-Start Surrey
REFERRAL FORM

Please note that all referrals must be made with the consent of the family, and have at least one child under 5.

- Have you discussed this referral with the family prior to completing this form? **YES / NO**
- Have you carried out a home visit with this family? **YES / NO**

To enable your referral to be processed please ensure that all 3 pages are fully completed.

Name of family: …………........................……………………………...……………...……………………………………………………....

Main Carer's Name: ....

Address : ……………………….……………………….………………………………........................…………………………….....……….

…………………………………………………………………………………. Postcode: ......……….....................………………………….

Tel No: ………………………...………..................................   Mobile No: ….......…………...……………….............................

Email:..….....................………...………………………..

Referred by:	
Name:	Family Doctor: ....
Role:	Surgery: ....
Agency:	Health Visitor: ....
Address:	Tel: ....
Postcode:	E mail: ....
Tel:	Other agencies involved:
E mail:	....
	…………………………………………………..…

Please √ all that apply to this family:

Lone parent	Substance abuse	Domestic abuse	Mental health issues	Learning disabilities	Post natal depression	Interpreter required	Teenage pregnancy 19 yrs or younger

Are there any **Health & Safety** issues we need to consider when placing a volunteer with this family? (please give details):

Has this family been referred to or supported by Home-Start previously? **YES/NO**

Has an **Early Help Assessment** been completed for this family? **YES/ NO**

If yes, please provide a copy with this referral.

If Yes, **Lead Professional** name: ....

Agency: ....   Tel: :..

Email: …………………………………………...……………………………….……………………………………….........

*Please provide details of **all** people **resident in the household**:*

	Members of the family:	Gender: **M / F**	Date of Birth	Asylum Seeker √	Refugee √	Considered to be disabled? (by self / main carer) √	Ethnic Origin? **(See Codes below)**	Child Protection Plan? * **Y/ N**	Child in need? * **Y / N**	Early Help Assessment or other assessment? **Y/N**
Adults that live with the children	Mother/partner name inc. surname:									
	Father/partner name inc. surname:									
	Other adult(s) living in household: (e.g. grandparent)									
Children incl. surname	**Children - Eldest to youngest please** c1.									
	c2.									
	c3.									
	c4.									
	c5.									
	c6.									

*** *If there is a CP or CIN plan in place please provide further information overleaf as to the reasons/circumstances***

Ethnic Origins:

Asian :	**White:**	**Black:**	**Mixed Ethnic Background:**
Indian = I	British = WB	African = BA	White/Black African = MB
Pakistani = P	Irish= WI	Caribbean= BC	White/Black Caribbean = MC
Bangladeshi= B	East European = EE	Black Other = BO	White and Asian = MA
Chinese = C	Other European = OE		Mixed Other = MO
Japanese = J	Traveller = T	**Other Ethnicities:**	
Asian Other = AO	White Other (eg American) = WO	Arab = A	
		Other Ethnic Group = O	*Please state: ……*

FAMILY NEEDS So that we can offer the family the most appropriate support 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:

	✓	If you have ticked, please tell us why this is a need and how a volunteer might be able to help
1 Managing the child(ren)'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/ emotional 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		
13 Use of services		
14 Other (please describe)		

Please add any background information that you think we would find useful overleaf.

Referrer's signature ……..... Date ……

(optional) Parent's signature …….....

If not signed please indicate that verbal consent has been given by the Parent

In order for us to process this referral you must have obtained consent for this information to be processed lawfully under the GDPR guidelines. A Privacy Notice is available to view at www.homestartraw.org

We will respond to you within two weeks to tell you about progress with this referral.

Please return the form to:

Home-Start Runnymede and Woking, 1st Floor, Foxwell House, 2 Chobham Road, Ottershaw. KT16 0NL
or via email to: info@homestartraw.org Tel: 01483 740367