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| **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 the form? (Please circle)** | **YES** | **NO** |
| Date referral is being made: |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family Names** |  | | | |
| **Address (including town)** |  | | | |
| **Postcode** |  | | | |
| **Telephone number** |  | | | |
| **Mobile number** |  | |  | |
| **Email** |  | | | |
|  | **Mother/Main Carer** | | **Father/Partner** | |
| **Name and Surname** |  | |  | |
| **Date of birth** |  | |  | |
| **Relationship to Children** |  | |  | |
| **Ethnicity** |  | |  | |
| **Resident in household** | Yes | No | Yes | No |
| **Main carer** | Yes | No | Yes | No |
| **Consider themselves to be disabled** | Yes | No | Yes | No |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Record the names of children aged 11 years or under only** | **Date of Birth** | **M/**  **F** | **Ethnicity \*\*** | **Considered**  **to be**  **disabled**  **by main**  **carer? Y / N** | **Is child undergoing**  **CAF / TAC procedures?** | **Who is lead**  **Professional?** | **Child in Need 🗸** | **Child protection 🗸** |
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| \*\* Ethnicity codes | (1) Indian | (2) Pakistani | (3) Bangladeshi | (4) Other Asian | (5) Black Caribbean | (6) Black African |
| (7) Black Other | (8) Chinese | (9) Other Ethnic | (10) Any Mixed | (11) White British | (12) White Irish | (13) Other White |

**FAMILY INFORMATION**

|  |  |
| --- | --- |
| Any other agencies involved: |  |
| Background information (Please use separate sheet if required): |  |

**Please tick all that apply to this family:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Lone parent | substance abuse or history of substance abuse | domestic abuse | mental health issues | learning disabilities | post natal depression |
| interpreter required | teenage pregnancy 19yrs or younger | | School readiness | Limited access to transport | Finance Issues |

So that we can offer the family the most appropriate support, and match the most suitable volunteer, please complete the following table. Please note there is **not** a ‘points’ system.

Families will not be prioritised on how many categories are ticked.

|  |  |  |
| --- | --- | --- |
|  | **Please tick** | **Please tell us why this is a need** |
| 1. Managing children’s behaviour |  |  |
| 2. Being involved in the children’s development/learning |  |  |
| 3. Coping with own physical health |  |  |
| 4. Coping with own mental health |  |  |
| 5. Coping with feeling isolated |  |  |
| 6. Parents self esteem |  |  |
| 7. Coping with child’s physical health |  |  |
| 8. Coping with child’s mental health |  |  |
| 9. Managing the household budget or debts |  |  |
| 10. The day to day running of the house |  |  |
| 11. Stress caused by conflict in the family |  |  |
| 12. Coping with multiple birth/ multiple children under 5 |  |  |
| 13. Use of other services |  |  |
| 14. Other |  |  |
| 15. Parents own learning needs |  |  |
| Would Family Group Support be beneficial? | Yes/No |  |
| Does the family have any connection to the Military? | Yes/No | Details: |

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| **Are there any Health and Safety issues/risk factors that we need to consider when placing a volunteer with this family?** |

Continued…….

**The family should be informed that Families Together Suffolk retains essential information about their support which is used by for monitoring and evaluation purposes.**

**These records are kept securely and are subject to the provisions of the Data Protection Policy and Confidentiality Policy.**

|  |  |  |  |
| --- | --- | --- | --- |
| Referred By: |  | Role: |  |
| Agency & Address: |  | | |
| Telephone No: |  | Email Address: |  |
| Referrers Signature: |  | Date: |  |
| Parents Signature (where possible) |  | Date: |  |

**Please return to Families Together Suffolk via email or post:**

info@familiestogethersuffolk.org.uk or

Families Together Suffolk, 20 Broad Street, Eye, Suffolk IP23 7AF