Please note: All referrals must be made with the consent of the family, the form must be fully completed, and ***the family must live in York & have at least one child under the age of five years.***

**This form will be held in confidence but may be shown to the family if requested.** We try to respond to all referrers within 3 weeks after receiving the referral and to report progress.  If you have any issues or concerns about the referral process or the support for the family please contact *us on* [*support@homestartyork.org*](mailto:support@homestartyork.org)

SERVICE REQUESTED: Please select by highlighting the option below

|  |  |  |  |
| --- | --- | --- | --- |
| **PERINATAL (PIMH)** | **HOME VISITING** | **GROUPS** | **SCHOOL READINESS** |

**Referred by: Your Details DATE:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Your Name:** |  | **Role:** |  |
| **Address:** |  | **Agency:** |  |
|  |  | **Tel:** |  |
| **Post code:** |  | **Email:** |  |

**Family details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parent 1**  **full Name:** |  | | **D.O.B**  **/ /** | **Ethnicity** |
| **Address:** |  | | |  |
| **Postcode:** |  | | | |
| **Mobile:** |  | | | |
| **E-mail::** |  | | | |
| **Parent 2**  **full name** |  | | **D.O.B**  **/ /** | **Ethnicity** |
| **Currently resident in Home?** |  | **Parental Responsibility: YES / NO** | | |
| **Doctor & Surgery** |  | | | |
| **Health Visitor** |  | | | |
| **School / Nursery**  **Details**  **Other agencies currently providing support** |  | | | |
|  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please tick all boxes that apply to this families needs**  **Housing** | | | | | | | | | | | | |
| **Private owned** |  | **Private rented** |  | **Family in temporary accommodation (B and B, hostel** |  | **Household in social local authority housing** |  | **Overcrowded housing [defined as more than 3 people per room]** |  | **Military Housing** |  |
| **Other Needs** | | | | | | | | | | | | |
| **Availiable Transport** |  | **Physical Disability** |  | **Young parent Lone parent**  **(Under 19yrs)** |  | **Speech & Lang** |  | **Current Pregnancy** |  | **Smokers in the home** |  |
| **Finance issues** |  | **Learning disabilites** |  | **Asyleem Seeker or refugee** |  | **CMHT involvement** |  | **Post-natal depression/risk** |  | **Pets in the home** |  |
| **Forces Family** |  | **Mental health** |  | **Prison** |  | **Seeking Employment** |  | **Domestic Abuse** |  | **Substance/Alcohol misuse** |  |
| **If you have ticked boxes above please add any background information that you think we would find useful**  **Are there any health and safety issues arising from your risk assessment that we need to be aware of?** | | | | | | | | | | | | |

**Parents 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:**

|  |  |  |
| --- | --- | --- |
| **Parents needs** |  | **If you have ticked, please tell us why this is a need** |
| 1. Managing child’s behaviour (including newborns) |  |  |
| 1. Being involved in the child(ren)’s development   (Including newborns) |  |  |
| 1. Coping with own physical health |  |  |
| 1. Coping with own mental health |  |  |
| 1. Coping with feeling isolated |  |  |
| 1. Parent’s self-esteem |  |  |
| 1. Coping with child’s physical health |  |  |
| 1. Coping with child’s mental health |  |  |
| 1. Managing the household budget |  |  |
| 1. The day-to-day running of the house |  |  |
| 1. Stress caused by conflict in the family |  |  |
| 1. Multiple births related issues |  |  |
| 1. Use of services |  |  |
| 14.Parents own learning needs |  |  |
| 15.Pregnancy (number of weeks at completion of this form) |  |  |

**Childrens Details**

**Details of any assessments for children’s needs –** Is any child subject to an assessment of needs such as **FEHA , Family Focus, Child in Need** plan?

NB: We **DO NOT** work with families currently on a Protection Plan. **If no intervention involved please put N/A**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full name of all children | Gender | Date of Birth or due date | Age at referral | Ethnicity | Name and agency of lead professional for intervention |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |

|  |  |
| --- | --- |
| **Have you discussed this referral with the family prior to completing this form?** | YES / NO |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Consent to share & Store information given in line with GDPR** | **Yes** |  | **No** |  | **Verbal** |  |
| **DATE / /** | | | | | **Written** |  |
| **Referrer’s signature:** |  | | | | | |
| **Print name** |  | | | | | |
| **Parent signature** |  | | | | | |
| **Print name** |  | | | | | |

**Thank you for taking time to provide this information which will help us to process the referral. We will try to respond to you within three weeks to tell you about progress with this referral.**