Home-Start Ealing
Hanwell Children's Centre
25a Laurel Gardens, W7 3JG
T 0208 842 1617
E admin@homestartealing.org
W www.home-startealing.org.uk

Support and friendship for families

REFERRAL FORM

Family No: ..... *(for Home-Start use only)*

Date Referral Received: .....
(Home-Start office use only)

Home-Start Ealing

DATA PROTECTION

Please password protect this referral prior to emailing it to us and send us the password in a separate email. The Service User MUST give written/verbal consent for us to hold their details before we can provide support (please see last page).

(This form will be held in confidence but may be shown to the family if requested)

HAS THE FAMILY AGREED TO THIS REFERRAL? YES/NO

PARENT(S)	Mother/Partner	Father/Partner
First Name		
Last Name		
Main Carer	Yes/No	Yes/No
Address		
Postcode		
Home Telephone No.		
Mobile Telephone No.		
Email Address:		
Ethnic Origin *(codes - overleaf)*		
Do they consider themselves to be disabled?	Yes/No	Yes/No
Special Needs *(please state)*		
Date of Birth		
What Languages are spoken and/or understood?		
Immigration status	Asylum seeker Yes/No Refugee Yes/No	Asylum seeker Yes/No Refugee Yes/No

CHILDREN (under 18)	1	2	3	4	5
First Name					
Last Name					
Gender	Male/Female	Male/Female	Male/Female	Male/Female	Male/Female
Date of Birth					
Ethnic Origin *(see codes - overleaf)*					
Considered disabled by main carer?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

Special Needs *(please state)*					
Child in Need Child Protection Plan	Yes/No Yes/No	Yes/No Yes/No	Yes/No Yes/No	Yes/No Yes/No	Yes/No Yes/No
Asylum Seeker Refugee	Yes/No Yes/No	Yes/No Yes/No	Yes/No Yes/No	Yes/No Yes/No	Yes/No Yes/No
School/Nursery Details					

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

Name	Relationship to child/ren e.g. grandparent	Gender	Date of Birth	Ethnic Origin *(see codes below)*	Do they consider themselves to be disabled	Asylum Seeker/ Refugee
					Yes/No	Yes/No
					Yes/No	Yes/No

Details of any assessments for children's needs – Is any child subject to an assessment of needs such as CAF? Yes/no

Name of child	Subject to an assessment of needs such as a CAF		Name and agency of lead professional
	Yes	No	
1.			
2.			
3.			
4.			
5.			

REFERRAL	Referred by	Health Visitor	Family Doctor
Name			
Dept/Organisation			
Address			
Postcode			
Telephone no.			
Email Address:			
Have you informed them of this referral?		Yes/no	Yes/no
Self Referral?	Yes/no		

If the family is receiving any other support which you feel would be beneficial for us to know please detail below:

Ethnicity Codes	
White **A** White British **B** White Irish	**Mixed** **H** White and Black Caribbean **J** White and African

C White Other	**K** White and Asian **L** Any other mixed background – please state
Asian or Asian British **D** Indian **E** Pakistani **F** Bangladeshi **G** Any other Asian background – please state	**Black or Black British** **M** Caribbean **N** African **O** Any other Black background – please state
P Chinese	**Q** Any Other Ethnic Group

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 also helps us to evaluate the outcomes of our support.

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 and how a volunteer maybe able to help*
1	Managing child's behaviour		
2	Being involved with 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 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 under 5		
13	Use of Services		
14	Other (please describe)		

Please tell us about any Health and Safety issues that we need to consider when assessing the potential for matching a volunteer with this family

Please tell us if the family has any issues relating to (please circle):

Lone parent /	Drug/alcohol abuse	Domestic violence	Post-natal depression	Mental health

Please feel free to attach any background information that you think we would find useful on a separate sheet of paper.

Referrer's Signature: _____ Date: _____

Office Use Only
Date Referral entered on MESH System: _____

Co-ordinator Involvement	
Co-ordinator: …… Date of Initial Visit: …… Date of Review Visits: 1) …… 2) …… 3) ……	Date of Final Review: …… Date of withdrawal of Home-Start Support: …… Date Referral Closed on MESH System: ……

Support	
Home-visiting by volunteer Name of volunteer: …… Date introduced: …… Date home-visiting ended: ……	
Home-visiting by Family Support Worker Name of FSW: …… Date introduced: …… Date home-visiting ended: ……	**Occasional support** Co-ordinator: …… Date started: …… Date ended: ……

PRESENTING ISSUE					
Post natal depression		Drug/alcohol dependence		Bereavement issues	
Other mental health Illness		Domestic violence		Housing problems	
Physical health (adult)		Learning difficulties (adult)		Young parent	
Physical health (child)		Learning difficulties (child)		Lonely/isolation	
Child with behaviour problems		Multiple birth/several young children		Little or no support	
Any other reason – please state:					

REFERRAL NOT TAKEN UP/INAPPROPRIATE		
Enabled family to find more appropriate support	Family found alternative support	Volunteer not required
Lack of suitable volunteer	No volunteer available	Unsuitable referral
Other (please specify)		

DATA PROTECTION

Home-Start Ealing will hold the information provided in this document in confidence, but it may be shown to the Service User if they request it. Information provided by the Referrer and Service User will be uploaded to our secure database and used only for the purpose of providing support to the Service user or, with their additional consent, for sign-posting to other service providers. Details of the referral can be shown to the Service user and/or Referrer on request.

CONSENT for storage of Service User's and Referrer's details

Service user's consent given Yes/no

Service user's signature (optional).....

Print name .....date.....

Referrer's consent given Yes/no

Referrer's signature.....

Print name.....date.....

Thank you for providing this information which will help us to process the referral and provide support.
Consent may be withdrawn at any time by contacting Home-Start in writing.
Data will be deleted from our system and database within 48 hours of the request being made.