Home-Start Kirkcaldy

REFERRAL FORM

Date received _____ **FAMILY No** _____ **REFERRAL no** _____

(for office use only)

Please note that all referrals must be made with the consent of the family. ***Please note the family must have at least one child under the age of five years.***

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

Please complete all sections otherwise the form may be returned.

MOTHER'S NAME _____ Date of birth _____

TEL _____ Mob _____

FATHER'S NAME _____ Date of birth _____

ADDRESS _____

_____ Postcode _____

Details of other members of the household with responsibilities for caring for the children, e.g. partners, grandparents, other family members.

_____

_____

Please give details of **ALL** children in family.

Name of child	Date of birth	School/Nursery attended	Child protection register	Registered disabled
			Yes / No	Yes / No

MOTHER'S OCCUPATION _____/ UNEMPLOYED

FATHERS' OCCUPATION _____/ UNEMPLOYED

Referred by: Name _____ Self _____ Agency _____ Address _____ _____ _____ Postcode _____ Tel _____ Email _____	Family Doctor _____ Tel _____ Health Visitor _____ Tel _____ Other Agencies involved _____ _____ _____ _____

Background information

Please tell us about any Health and Safety issues that we need to consider when placing a volunteer with this family.

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

Lone parent
Substance abuse
Domestic abuse
Mental health issues
Learning disabilities
Post-natal depression
Teenage pregnancy 19 yrs or younger
Other (please specify)

Reason for volunteer

Focus for volunteer

Any additional comments

So that we can offer the family the most appropriate support, and match the most suitable volunteer, please complete the following table. This information helps us to evaluate the outcomes of our support.

- Please note that there is not a 'points' system. Families will not be prioritised on the basis of how many categories are ticked.

I hope that Home-Start Kirkcaldy 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 help**
1. Managing child'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 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 other services		
14. Other (please describe)		

Ethnicity of main carer:

Asian or Asian British			
Indian ❑	Pakistani ❑	Bangladeshi ❑	Other Asian ❑
Black or Black British			
Caribbean ❑	African ❑	Other ❑	
Chinese or other Ethnic Group			
Chinese ❑	Other Ethnic ❑		
Mixed			
Any mixed ❑			
White			
British ❑	Irish ❑	Other White ❑	

FIFE COUNCIL CRITERIA - CHILDREN'S NEEDS

Please indicate which of the following apply to the child/ren within the family:

1. Child/ren 'Looked After' at home or with relatives. YES/NO

2. Child/ren at risk of being placed on the Child Protection Register. YES/NO
   If so, please describe the risk factors:

3. Child/ren on the Child Protection Register. YES/NO
   If so, state Registration Category:

4. Child/ren at risk of becoming 'Looked After'. YES/NO
   If so, please describe the risk factors:

5. Child/ren with ongoing health needs/ are failing to thrive. YES/NO
   If so, describe these needs:

6. Child/ren have significant identified issues at nursery/school. YES/NO
   If so, describe these concerns:

7. Child/ren are referred to/ at risk of referral to the Reporter. YES/NO
   If so, describe the risk factors:

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

We aim to respond to all referrers within 2 weeks after receiving the referral to report progress. If you have any issues or concerns about the referral process or the support for the family please contact Eleanor Thomson at the address below.

Please return this completed form to:

Eleanor Thomson
Senior Co-ordinator
Home-Start Kirkcaldy
5 South Fergus Place
KIRKCALDY
KY1 1YA

Tel: 01592 565285
FAX: 01592 594503
Email: homestartkirkcaldy@yahoo.co.uk

Referrer's signature _____ Date _____

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

Data Protection

Home-Start Kirkcaldy will keep this form on file for future reference.
Information will not be passed onto other agencies without permission.