

HOME-START DERBY REFERRAL FORM

Scheme code:DER..... Date referral received (scheme use) _____



- 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 this form? YES / NO
- The family must 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

Name of family..... Family Number (scheme use).....

Address.....

.....Postcode

Tel. No Mobile No E mail

Please provide some details about the adults caring for the child[ren]:

		Name	DOB	Main carer ✓	Resident in household ✓	Comments/Additional information (Disability/Language/Faith etc)
Mother/partner						
Father/partner						
Other main carer[s]						
Other main carer[s]						

Lone parent	substance abuse	domestic abuse	mental health issues	learning disabilities	post natal depression	interpreter required	teenage pregnancy 19yrs or younger	other please specify
-------------	-----------------	----------------	----------------------	-----------------------	-----------------------	----------------------	------------------------------------	----------------------

Children M/F	Name	DOB	CIN/ CPP	Nursery/School	Comments - eg Disability etc (see next page for details)
C1					
C2					
C3					
C4					
C5					
C6					

Referred by:

Name	Family Doctor
Role	Tel
Agency	Health Visitor
Address	Tel
Postcode	Other agencies involved
Tel	

What are the positives? :

.....

Please add any Health and Safety background information that you think we would find useful (if necessary attach an extra sheet)

.....

Smoking: Yes/No	Pets
------------------------	-------------

Details of children - Please note the family must have at least one child under the age of five years, (please include details of all children under 18)

Child's name Eldest first	Immigration status			Considered to be disabled by main carer? ✓/if yes	Asian or Asian British				Black or Black British			Chinese or Other Ethnic Group		Mixed	White			Subject to assessment of needs e.g. CAF/ UNOCINI (✓)	Who is the lead professional?	Child in need ✓	Child care/ protection plan (✓)	Nursery or School
	Asylum	Refugee	Pending		Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese	Other Ethnic	Any mixed	British	Irish	Other White					
C1																						
C2																						
C3																						
C4																						
C5																						
C6																						

Please complete those boxes which apply to any of the children Note: the terms above are nation-specific – not all will be relevant in your area

Details of other members of the household with responsibilities for caring for the children	Gender		Date of birth	Immigration status			Consider themselves to be disabled YES?	Asian or Asian British				Black or Black British			Chinese or Other Ethnic Group		Mixed	White		
	Male	Female		Asylum seeker	Refugee	Pending		Indian	Pakistani	Bngldshi	Other	Caribbean	African	Other	Chinese	Other	Any	British	Irish	Other
Main Carer																				
Partner living in household																				

D12. Coping with multiple birth/multiple children under 5		
D13. Use of services		
D14. Other – Improve lifestyle – home environment/ poverty/ debts/well-being		

FOR OFFICE USE ONLY		
Has the family received Home-Start support previously Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes when did the Home-Start support cease Date: _____		
Date of organiser's first visit:	Name of Volunteer:	
Date of introduction of volunteer:		Date of withdrawal of Home-Start support:
Referral not taken up/inappropriate		
Enabled family to find other more appropriate support	Family found alternative support	Volunteer not required
Lack of suitable volunteer	No volunteers available	Lack of scheme resources
Unsuitable referral	Other (please specify)	

Organiser allocated and response to family within 7 days to arrange home visit

Organiser

Home Visit -

- Information leaflet
- Information on Safeguarding/Confidentiality policy
- Risk assessment
- Needs assessment

Initial Visit letter sent - Date- copied to referrer

Family linked to volunteer - referrer informed - Date

If no suitable volunteer available contact family within 6 weeks
 Or send letter (remain waiting and reply slip)
 To be returned by:
 Copied to referrer

Family no longer require support - referrer informed - Date.....

Family wish to wait for suitable volunteer - referrer informed