Family Referral

**Date of referral:** / /

Please send this form via secure e-mail to Early.intervention@redbridge.gov.uk . For advice on completing the form, and information on an Early Help Assessment, please contact the CAF Team on 0208 708 2612.

**Unborn/baby/child/young person and family members** (that should be considered in any assessment, including those not in the home)

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| --- | --- | --- | --- | --- | --- |
| **Full Name** | **Gender** | **Ethnicity** | **Date of Birth or EDD** | **Full address** | **Postcode** |
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**Details of parents/carers**

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| --- | --- | --- | --- | --- | --- | --- |
| **Relationships**  | **Full Name** | **Ethnicity** | **PR\*** | **Date of birth** | **Full address** (including postcode) | **Contact number/ Email** (if appropriate) |
| **Father** *(if not included state reason)* |  |  |[ ]   |  |  |
| **Mother** *(if not included state reason)* |  |  |[ ]   |  |  |
|  |  |  |[ ]   |  |  |
|  |  |  |[ ]   |  |  |

\*PR= Parental responsibility

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| **Does the child/young person have a private fostering arrangement or legal order directing placement?****If yes, please give details.** |
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**Person making the referral**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Role/Establishment** | **Address** | **Contact Number** | **E-mail** |
|  |  |  |  |  |

**Special Requirements**

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| **Additional Cultural Information** (useful for example for linking with other services/home visits) |
| Parents first language |  | Childs first language |  | Religion |  |
| Immigration status: |  |
| Does child/young person have a disability [ ]  If yes, please give details of the disability, include the name of which child/young person and the support they require. |
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| Detail below any special requirements (for child and or their parent) for example, signing, interpretation or access needs |
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**Professionals involved with the family**

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| **Please identify other services already involved (e.g. GP, EP, Health Visitor, School Nurse, EWMHS, Speech & Language Therapy, SENCO, YOT, Adult Mental Health, R3 etc.)** |
| **Service** | **Name of professional** | **Service** | **Contact Details** |
| **Nursery/school/college** |  |  |  |
| **GP** |  |  |  |
| **Health Visitor** |  |  |  |
| **Other Services** (EP, SALT, CC, CAMHS, SW etc) |  |  |  |

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| **Consent**  |
| The referrer confirms the family have consented to this referral and they understand that their information will be shared with agencies that may be able to help or support their child and / or family. **Yes [ ]  No [ ]** ***Please detail what discussion has taken place with the parent/carer to gain consent.***……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………*Please note the information above will be stored securely on our early help system.* |

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| **Reasons for the referral:** |
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##### Safeguarding statement

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|  **“The assessing practitioner concludes there is currently no risk of significant harm to the child or young person.”**Tick here to indicate agreement with this statement: **[ ]**  Yes **[ ]**  No \*\* If you have ticked ‘no’ please follow the [London Safeguarding Children Procedures and Practice Guidance](https://www.londonsafeguardingchildrenprocedures.co.uk/) and [Threshold Document: Continuum of Help and Support](https://www.londonsafeguardingchildrenprocedures.co.uk/thresholds.html) and refer to Children’s Social Care immediately\*\* |

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| **Which of the following services do you think would be appropriate (more than one can be chosen)?** |
| Family Support Worker Team (FSW) |  | Junior Family Intervention Team (JFIT) |  |
| Children with Disabilities (CWD) Early Help Offer  |  | Freedom Programme |  |
| Parenting Programme Group Intervention*Current concerns with child’s behaviour must be included in above reasons.*  |  | Freedom for Children  |  |
| Supporting Families Employment Advisor (SFEA) |  | Other (please specify) |  |