

HOME-START BOREHAMWOOD & DISTRICT

The BECC, Shakespeare Drive, Off Furzehill Road, Borehamwood, Herts WD6 2FD.

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REFERRAL FORM (Please visit our website for up to date version.)

WE ARE UNABLE TO PROCESS YOUR REFERRAL UNTIL WE RECEIVE THIS FORM (fully completed)

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 ___

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

DATE: _____ Home-Start Family Number (Official Use Only) _____

Name of family: _____ Housing problem YES/NO (for statistical information)

Address: _____

Post Code: _____ House Flat Home No.: _____ Mob No.: _____

Name of mother: _____ Main Carer YES/NO Main Carer age group

Name of father/partner: _____ Main Carer YES/NO

<25	
25-44	
45-65	
>65	

Main Carer Registered Disabled YES/NO Single Parent YES/NO

Previously received H-S support or referred: yes/no Supported by another H-S: yes/no

Heritage

Scheme name _____

ASIAN or ASIAN BRITISH

BLACK or BLACK BRITISH

WHITE

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background
- Please specify _____

- Caribbean
- African
- Any other Black background
- Please specify _____

- British
- Irish
- Any other white background
- Please specify _____

CHINESE OR OTHER ETHNIC GROUP

MIXED

- Chinese
- Other ethnic group

- Any mixed background
- Please specify _____

Religious considerations/cultural issues

Please note the family must have at least one child under the age of five years. **ALL** children must be documented.

Name of Child	Name of school *	Date of Birth	Registered Disabled		Child Protection Plan	
			YES	NO	YES	NO

Referred by	Self		Tele No.
Agency		Family Doctor**	
Address		Health visitor	
		Other agencies involved (include contact numbers)	
Post code			
Tele No.			
Multiple agency involvement - CAF form completed Yes/No/In the process (delete as appropriate). If you are commencing, we would like to be part of the process.		Official use only Initial visit: DD/MM/YY 00:00	

*/**(In accordance to Hertfordshire Safeguarding Children Board & their updated audit; it is **essential** that we have school & GP details. Without this information we are unable to process your referral.)

N.B This form is regularly updated for quality assurance & statistical information. No photocopies accepted revised 02/10.

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. Please visit www.home-startbw.org.uk in regards to our confidentiality policy.

I hope that Home-Start will help meet needs the family has in the following areas:

<i>Please mark one box with a "P" for the family's PRIMARY concern then tick any others that are required.</i>	✓	<i>If you have ticked, please tell us why this is a need and how a volunteer might be able to help</i>
1 Feeling isolated		
2 Using other services/facilities in the area		
3 Parent(s) emotional health/well-being		
4 Parent(s) self-esteem		
5 Parent(s) physical health/well-being		
6 Child(ren)'s physical health/well-being		
7 Child(ren)'s emotional health/well-being		
8 Managing the child(ren)'s behaviour		
9 Being involved in the child(ren)'s development		
10 Stress caused by conflict in the family		
11 The day-to-day running of the house		
12 Managing the household budget		
13 Coping with the extra work caused by multiple birth/multiple children under 5		
14 Other (please describe)		

RISK ASSESSMENT

- ❖ Please tell us about any Health and Safety issues that we need to consider when placing a volunteer with this family, e.g. drug or alcohol abuse, domestic violence. If there has been a Domestic Violence Incident, are Police and CSF aware? Please give details.
- ❖ Is it recommended that we go in pairs on the first visit? YES/NO
- ❖ Please add any background information that you think we would find useful (if necessary attach an extra sheet).

Signed by referrer: _____ Date: _____

(Official use only) For self referrals

Call made to referrer to check Health/Safety/other issues YES/NO Date called: _____

Name: _____ Title: _____