Caerphilly Borough Common Referral Form

Date of referral

Is the child/YP/Adult aware of this referral? Yes ☐ No☐
If the child is under 16, is the parent/carer aware of this referral? Yes ☐ No ☐

Does parent/carer/child/young person/adult agree to the referral? Yes ☐ No☐

Does the family require an interpreter? Yes ☐ No ☐

Referrers Details

Referrers Name:	Self:☐ Professional:☐ If professional please state position:
Address:	Postcode:
Telephone Number:	Email:

Family Members

First Name	Surname	Relationship to child	PR?	D.O.B / E.D.D.	M/F	Ethnicity	Address	Telephone number	Who referral relates to (please tick)	Main Carer? (please tick)
			☐						☐	☐
			☐						☐	☐
			☐						☐	☐
			☐						☐	☐
			☐						☐	☐
			☐						☐	☐

First language in the home:
☐Welsh ☐English ☐ Other - Please specify:
Preferred language to contact:

Who is asking for help?	**Birthing History:**
☐ Child/Young Person ☐ Parent/Carer ☐ Practitioner	

Type of accommodation at referral?

☐ **Council**
☐ **Home Owner**
☐ **Housing Association** **Name of association:**
☐ **Private Rental** **Name of landlord:**

Who is coordinating the service e.g. Social Worker?

Under what category of need, if any, are the children known, please specify?

☐ **Child Protection**
☐ **LAC (Looked After Child)**
☐ **Child In Need**
☐ **Vulnerable with Additional Needs**

Who is coordinating the service e.g. Social Worker?

Are any of the following needs currently present? (please tick)	**Who does the issue relate to?**
☐ Drug & Alcohol	
☐ Mental Health inc emotional health	
☐ Learning difficulties	
☐ Poor housing inc conditions and evictions	
☐ Long term physical health	
☐ Separation	
☐ Domestic violence	
☐ Family violence	
☐ Disability	
☐ Bereavement	
☐ Poor child/parent relationships	
☐ School Attendance inc exclusions	
☐ Employment inc training and qualifications	
☐Teenage pregnancy	
☐ Involvement in crime/antisocial behaviour	
☐ Benefits inc completion online	
☐ Healthy living inc sexual health and smoking cessation	
☐ Basic Skills inc literacy, numeracy and IT use	
☐ Other please specify	

Reason for referral:

What would be a successful outcome for the family?

What would you recommend for the family?

Provide a description of current issues the family face, their strengths and the reasons why you feel the family would benefit from this service, please include families history with agencies:

Services Involved:

GP Name: **Telephone Number:**	**Address:**

Health Visitors Name (if applicable): **Telephone Number:**	**Address:**

Child's Name	Pre-School/Nursery/School/ College Name	Address	Telephone Number

Other Agencies involved:

Agency Name	Worker Name	Telephone Number	Family Member receiving service

Are there any potential risks?
Please see prompts below

Is the entrance to the home easy to access? (E.g. are there any obstacles) **Yes☐ No☐**

Are there likely to be visitors at the home when a worker calls? **Yes☐ No☐**

Are there any risks relating to the family/location (E.g dogs or unusual pets) **Yes☐ No☐**

Are they any issues we should be aware of in regards to health and safety within the home? **Yes☐ No☐**

How long has the family been known to you?

Do you think that this family possess a risk to others especially those that will work with them? If yes please comment: **Yes☐ No☐**

Are you happy for us to share this information with the family? **Yes☐ No☐**

Has the family given their permission to share information and receive support? **Yes☐ No☐**

Parental consent:

I understand that the information on this form will be added on the projects database, for administration, service delivery, monitoring and evaluation.

I understand that my details will be shared appropriately within the Families First / Flying Start/Communities First Programme and partner agencies for the benefit of meeting my family's needs in line with the Data Protection Act 1998, and that I can withdraw my consent at any time by informing the worker named below, both verbally and in writing.

I consent to be part of the Families First / Flying Start/Communities First Programme. I consent to Families First / Flying Start/Communities First sharing the information appropriately with the various relevant people within the Families First Programme and partner agencies for the benefit of my family.

Print name of parent/carer	Signature of parent/carer	Date

The person who signs this form must have legal responsibility for the children. In the case of Looked After Children the project must contact the Social Services Department.

Practitioner:

I have explained the purpose of the *(insert name of project)*……within the Families First/Flying Start/Communities First Programme to the parent/carer. I have explained the information sharing process and they have agreed to share their personal information. I believe that the parent/carer understands the information sharing process and consents to share their information. I have offered the parent/carer a copy of the information-sharing guide.

Print name of practitioner	Signature of practitioner	Date

I understand that the data will be stored and shared in accordance with the Data Protection Act 1998