



## **REFERRAL FORM**

**Home-Start Blackburn & Darwen**  
Suite 19, Kings Court, 33 King St,  
Blackburn BB2 2DH

t: 01254 692613  
e: hstart@btconnect.com

**PLEASE NOTE THAT ALL REFERRALS MUST BE MADE WITH  
THE CONSENT OF THE FAMILY.**

Home-Start Family No. (official use only) .....

NHS Patient No. (NHS Referrals ) .....



## FAMILY INFORMATION

Name of family	Date
Address	
Postcode	Tel
Name of mother	D.O.B.
Name of father	D.O.B.
Significant other	
Single parent    Yes <input type="checkbox"/> No <input type="checkbox"/>	Can person referred speak English    Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Ethnicity of main carer:</b>			
White	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Black Other	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Other <input type="checkbox"/> Please specify			

Name of child	D.O.B	M	F	School/Nursery / Childrens Centre attended

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

Referrer	Family Doctor
Agency	Tel
Address	Health Visitor
	Team
	Tel
Tel	CAF OPEN      YES/NO CAF LEAD PROFESSIONAL
E-mail	Agencies Involved

## Family needs

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, together with information provided by the family, will be used to monitor how our support meets the family's needs.

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

<i>Family needs</i>	✓	<i>If you have ticked, please tell us <u>why</u> this is a need</i>
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 services		
14. Other (please describe)		

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

Lone parent    Drug/Alcohol abuse    Domestic violence    Post-natal depression    Mental health

**Please add any background information which you think we would find useful.**

Please use extra sheet if necessary

**Are there any health and safety issues including family violence we need to consider?**

No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Please give brief details
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***We (the family) give the referrer consent to share our information with Home-Start***

***Family signature .....***

***Referrer signature .....***

### **Confidentiality**

*All personal information about parents and children is treated as confidential, to be discussed only as necessary with the Home-Start co-ordinator in support of the volunteer and to assist the family. Any disclosure of confidential information to any other person may only be undertaken with the expressed permission of the parents for the purpose of assisting the family, except where it is considered necessary for the welfare and protection of a child when information shall be shared with the appropriate authority.*

**Please note:** Links will be determined on the availability of volunteers at the time of referral. Unfortunately there are times when we are unable to link the referred family as quickly as we would like, which means they would have to go on a waiting list. We aim to respond, upon receipt of this referral, within 10 days.