

**HOME-START REFERRAL FORM**

*Scheme code:* LOR

*Home-Start Family number:*  
(For office use only)



**WE ARE UNABLE TO PROCESS YOUR REFERRAL UNTIL WE RECEIVE THIS FORM**

Please note that all referrals must be made with the consent of the family and the family must have at least one child under the age of five years.

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.**

We try to respond to all referrers within 2 weeks after receiving the referral to report progress. If you have any issues or concerns about the referral process or the support for the family please contact **Aileen Binner** (co-ordinator) 01631 566749.

**Name of family**.....**Date** .....

Address .....

..... Postcode .....

Tel No ..... Mobile No .....

Name of mother/partner ..... Main carer YES/NO

Name of father/partner ..... Main carer YES/NO

Please tell us if an interpreter is required for this family YES / NO

<b>Referred by:</b>	
Name _____ Self _____	Family Doctor _____
Agency _____	Tel _____
Address _____	Health Visitor _____
_____	Tel _____
_____	Other Agencies involved
Postcode _____	_____
Tel _____	_____

## 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:**

Family needs	✓	If you have ticked, please tell us <u>why</u> this is a need
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 about any Health and Safety issues that we need to consider when placing a volunteer with this family:

.....  
 .....

- 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 that you think we would find useful (if necessary attach an extra sheet).



**Details of other members of the household with responsibilities for caring for the children**

	Gender		Date of birth	Immigration status		Do they consider themselves to be disabled?		Asian or Asian British				Black or Black British			Chinese or Other Ethnic Grp		Mixed	White		
	Male	Female		Asylum seeker	Refugee	YES	NO	Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese	Other Ethnic	Any mixed	British	Irish	Other White
Main Carer																				
Partner living in household																				
Other Please specify e.g. Grandparent																				

**Referrer's signature** ..... **Date** .....

**Parent's signature** ..... **Date** ..... *(optional)*

**Thank you for taking time to provide this information which will help us to process the referral.** We will try to respond to you within two weeks to tell you about progress with this referral.