**Family Support Partnership Referral Form**

**Reference Number:** ........................... **Date Received:** ………………………

(For Office Use Only)

**Referral Details:**

|  |  |
| --- | --- |
| Name of Parent/Carer |  |
| Address |  |
| Postcode: |  |
| Telephone Number |  |
| Email: |  |

**Details of children/YP:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name | Date of birth | Disability/health issues (please outline) | EHCP (Y/N) |
| Child/YP1 |  |  |  |  |
| Child/YP2 |  |  |  |  |
| Child/YP3 |  |  |  |  |

**Reason for Referral (main areas of support required)**

|  |
| --- |
| **Education:** **Social Care:****Health & Diagnosis:****Behaviour:****Emotional Support:****Other (please specify):** |

**Confirmation of Consent: PLEASE READ CAREFULLY THROUGH COMPLETED FORM BEFORE SIGNING**

I consent to myself/my family/my child (delete as appropriate) being referred to the Family Support Service.

I understand and agree with the information provided and the referral to the Family Support Service.

I understand that a further needs assessment may be required, in consultation with myself, in order to identify service(s) required.

I understand that in order to access an appropriate service there will be a need to share information about myself or my family with other relevant agencies, however this will be on an agreed ‘need to know’ basis.

**\*Signed** ………………………………………… (Parent/Person with Parental Responsibility/Individual)

**Date** ……………………

|  |  |  |
| --- | --- | --- |
|  | **Referred By:** | **Contact Details** |
|  | **Name:** | **Address:** |
|  | **Agency:** | **Post code:** |
|  | **Date:** | **Tel. No:** |
|  |  |
|  |  | **Email:** |

**I confirm that the parent/carer has provided their consent as stated in the consent statement above**

**Signed** …………………………………….(Referrer) **Date** ……………….

***Family Support Service Referral Record***

**For office use only (Partnership Administrator)**

|  |  |
| --- | --- |
| **Referral Form Identifier Number:** | **Date Referral Received:** |
|  |  |  |
| **Previously Referred to Hub: Y/N** | **Referred to FSO (state name):** |
|  |  |  |
| **DISTRICT & WARD:** | **Referral partner (Please tick)****For Us Too: IU2: S2BM:** |
|  |  |
| **Referred to other service or agency: (Please specify)** | **Service declined by parent/carer: Y/N** |
|  |  |
| **For completion by FSO** |  |  |
| **Decision made by the Family Support** |  |  |
| **Officer** |  |  |
| Accepted onto programme |  |  |
| Accepted but family did not engage |  |  |
| Unable to meet need of referred family |  |  |
| Rejected for other reason **(Please Specify)** |  |  |
| Referred to other agency/service (Please specify) |  |  |
| **Initial Input** |  |  |
| Initial Assessment completed |  |  |
|  |  |  |
| Action plan completed |  |  |
|  |  |  |
| **Outcomes of Service Intervention** |  |  |
|  Completed programme with a positive |  |  |
|  outcome |  |  |
| Completed the programme with no |  |  |
| positive outcome |  |  |

**FSO Signature ……………………………………………………………**

**Date …………………………………………………**