Putting the Community First

BARNET LONDON BOROUGH

Children's Centre Referral Form

Children's Centres can offer families who have children under five a range of services which include parenting support and advice, activities for children, mothers, fathers and carers, access to health services, breastfeeding support and baby bonding groups. Also provided are adult learning opportunities and advice and support on benefits and employment

Referrals must be discussed and agreed with the family and signed consent given

1. DETAILS OF MAIN PARENT/CARER		**REFERRAL DATE:**
First name:	Last/Family name:	Any other names used:
DOB:	Gender:	Ethnicity:
Is English their first language? Child ☐ Yes ☐ No Parent ☐ Yes ☐ No	If no, specify preferred language:	
Ability to read English ☐ Yes ☐ No	Ability to write English ☐ Yes ☐ No	
Religion:	Relationship to the children being referred:	
Present address:	Previous address if at present address less than one year:	
Postcode:	Postcode:	
Home telephone:	Mobile phone:	

2. REASON FOR REFERRAL

Please detail why you are requesting a service, clearly specifying areas of concern, and the evidence you have to support this. *For example, parenting capacity, child's behaviour or environment*

3. DETAILS OF CHILD/CHILDREN BEING REFERRED

Childs name	DOB	Gender	Ethnicity	Child Protection	Child in need

				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

What language is spoken at home?	

Are there any special needs or disabilities in the family:

Do you have consent for this referral ☐ Yes ☐ No	If yes, who gave consent:

4. Additional information about the child/children's family

Household members	**Relationship to child**	**DOB**	**School/Preschool**	**Does this person hold Parental responsibility**

Other significant adults	**Relationship to child**	**DOB**	**Address**	**Does this person hold Parental responsibility**

Health Visitor name and address:	GP name and address
Phone no:	Phone no:

5. Are you aware of any other agencies involved with the child/family *For example, Social Worker, Police, Probation Service, Early Years Service Family Focus Team, Voluntary sector organisation*			
Practitioner name	Job title	Agency	**Telephone/contact details**

6. Has there been a CAF initiated for this family?	
☐ Yes CAF number: Name and contact details of Lead Professional:	☐ No Please identify why not undertaken:

Do you have consent to share the CAF information as part of this referral? ☐ Yes ☐ No

7. SERVICE/S REQUESTED

☐ 2YR funding	☐ Family Support/Outreach	☐ Oral Health	☐ Legal Advice
☐ Adult Learning	☐ Breastfeeding support	☐ Welfare Rights	☐ Parenting skills
☐ Safer Families (DV)	☐ Speech and Language	☐ Antenatal Support	☐ Healthy Start vitamins
☐ Stay and Play	☐ Special needs support	☐ CAF assessment	☐ Bookstart/read & rhyme
☐ Healthy eating/weaning	☐ Immunisation advice	☐ Smoking Cessation	☐ Baby Bonding
Other:			

8. EXPECTED OUTCOME

9. REFERRER DETAILS	
Name	Agency
Address:	
Email address:	Contact number:
Please tick this box if you are a parent making a self referral ☐	

Referral Type	☐ visit	☐ telephone	☐ self	☐ email	☐ postal	☐ fax

Which Children's Centre are you referring the family to?	

☐ please tick if you are using a continuation sheet

Signature of referrer:	Date of referral:

Parent signature:	Date:

Please return the completed form to the Children's Centre you are making the referral to, or call 020 8359 7616 for confirmation of the family's local Children's Centre

Office Use only:	