

# HOME-START STOKE-ON-TRENT

The Family Centre, Eastwood Road, Hanley, S-o-T, ST1 3LR

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**NOTE:** It is Home-Start's policy to only accept referrals with families' consent.

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 Chris Pointon.

Referral Form <span style="float: right;">(for office use only)</span>					
Date of Referral:		Family No:	Date received:		
Family Name:		<b>Housing (please tick to confirm):</b> <input type="checkbox"/> Private <input type="checkbox"/> Housing Association <input type="checkbox"/> City Council  <b>Any other issues identified:</b> <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Health and Safety			
Address:					
Postcode:					
Telephone - Home:					
Telephone - Mobile:					
		<b>Father/Partner</b>		<b>Mother/Partner</b>	
Name:					
Date of Birth:					
Ethnic Origin: <i>(please circle)</i>		White Irish Black Caribbean Black African Black Other	Indian Pakistani Bangladeshi Chinese Other	White Irish Black Caribbean Black African Black Other	Indian Pakistani Bangladeshi Chinese Other
Employed <i>(please circle)</i>		YES/NO		YES/NO	
Please tell us if an interpreter is required for this family <span style="float: right;">yes <input type="checkbox"/> no <input type="checkbox"/></span>					
Names of all children in family	Date of birth	School Attended	Care Order	Ch.Protectn Register	
Referred by: <i>(please print your name, agency if applicable and address)</i>					
Tel No: <span style="float: right;">Please tick that the family have agreed to this referral <input type="checkbox"/></span>					
Referred by Self					
Family Doctor		Tel No.:			
Health Visitor		Tel No.:			
Other Agencies Involved:					

*For office use only:*

Health Visitor	Other Health referrals	Social Worker	Other S S's/Social Work referrals
Children's Centre	Self	Other	

## Referral Form

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.

It will be helpful if you could supply as much information as possible. This information also helps us to evaluate the outcomes of our support.

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

		✓	If you have ticked, please tell us why this is a need and how Home-Start might be able to help
1	Feeling isolated		
2	Using other services/facilities in the area		
3	Parent(s) emotional health/well-being		
4	Parent(s) self-esteem		
5	Parent(s) physical health/well-being		
6	Child(ren)'s physical health/well-being		
7	Child(ren)'s emotional health/well-being		
8	Managing the child(ren)'s behaviour		
9	Being involved in the child(ren)'s development		
10	Stress caused by conflict in the family		
11	The day-to-day running of the house		
12	Managing the household budget		
13	Coping with the extra work caused by multiple birth/multiple children under 5		
14	Other (please describe)		

Background Information:

Please outline any medical problems in the family:

Any additional comments:

Any issues relating to health and safety:

Has this family received Home-Start support previously?

yes

no

If yes, when did the Home-Start support cease?

Date: .....

Please provide some details about the children and adults caring for them:

**Details of Children** Please note the family must have at least one child under the age of five years, (please include details of all children under 18)

Name of child	School Attended	Gender		Date of birth	Immigration status		Considered to be disabled by main carer?		On Child Protection Register or subject to childcare plan		Asian or Asian British				Black or Black British		Chinese or Other Ethnic Group		Mixed	White					
		Male	Female		Asylum seeker	Refugee	YES	NO	YES	NO	Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese		Other Ethnic	Any mixed	British	Irish	Other White	
1.																									
2.																									
3.																									
4.																									
5.																									
6.																									
7.																									

**Details of any assessments for children's needs**

Name of child	Subject to an assessment of needs such as CAF*/care order		Please detail and give name and agency of lead professional
	YES	NO	
1.			
2.			
3.			
4.			
5.			
6.			
7.			

\* or equivalent assessment in the 4 nations

### 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																				

**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 2 weeks to tell you about progress with this referral.

<b>FOR OFFICE USE ONLY:</b>			
Date of Co-ordinator's first visit:		Name of Volunteer/Family Support Worker:	
Date of introduction of Vol/FSW:		Date of introduction to Family Group:	Date of withdrawal of Home-Start support:
<b>Referral Not Taken Up/Inappropriate</b>			
Enabled family to find other more appropriate support	Family found alternative support	Volunteer not required	Unsuitable referral
Lack of suitable volunteer	No volunteers available	Lack of scheme resources	Other <i>(please specify)</i>