HOME-START KIRKLEES REFERRAL FORM

Please read the guidance for referrers to check that families are eligible for Home-Start support.

Please check the eligibility criteria and tick which type of support your referral is for:

Support type	Eligibility criteria	Tick if applicable
Home based or remote support (telephone befriending)	Family must have at least one child of pre-school age, or a child in their first term of full-time education	
Transition into first term of school support	A child who is in their first term of full-time education or due to start	
School Readiness Support	Up to 5 support sessions to help children identified as not being school ready or have developmental delay/learning needs	
Young Parents Support	Weekly group support for Young Parents aged 14-24 (parents must have a child 3 years or under to be eligible to attend)	
Peer Group Support	Weekly group support for parents/carers experiencing isolation & loneliness (parents must have a child 3 years or under to be eligible to attend)	
Are you a parent/carer referring your own family?		
Referrer: Please note that the type of support offered to a family will be assessed at initial visit and could be either remote, home based or in group and should not be pre-determined by either the family or referrer. Families will move between different types of support as appropriate.		

Date of referral:	**Family Ref Number:** (for H-S office use only)	
Family address: **Postcode:**	**Tel No.** **Mobile No of main carer.**	**Does the family have any pets?** (please specify which)
	Mother/Carer/Partner	**Father/Carer/Partner**
Full name		
Date of Birth		
Main carer? (✓)		
Resident in the house? (✓)		

Names of Children (please list eldest child first) All children listed must live in the family home	**Date of Birth**	**Gender or Identity**	**Has a family assessment been completed?** If so, please tick which one applies and **attach** the last set of minutes and plan for each that apply. **PLEASE NOTE: A delay in receiving these will affect the referral being processed.**		
			TAF	**Child in Need Plan**	**Child Protection Plan**

If any assessment is in place, please state the lead professional details:

Name:..... Agency:.....Contact No:.....

And date of next meeting:.....

Is the person you are referring pregnant? YES / NO	**Number of weeks pregnant at date of referral:** **(minimum 20 weeks)**

Referrer's name: **Referrer's Signature:**	**Agency:** **Address:** **Tel. No:** ***In the interests of economy and protecting the environment, we will acknowledge your referral & provide you with updates, where appropriate, by e-mail.*** **Referrer's e-mail address:**

Have you discussed & gained consent for this referral with the family? YES/NO

For self-referrals, do you consent to HSK contacting your health visitor/other professional involved with your family? YES/NO

Have you referred this family to other agencies? **YES/NO** Please specify:	Other workers involved with family: Name/Agency: Contact Number: Name/Agency: Contact Number: Name/Agency: Contact Number: Name/Agency: Contact Number:

Ethnic Origin of Main Carer (please tick appropriate box)											
WHITE		**MIXED RACE**		**ASIAN OR ASIAN BRITISH**		**BLACK OR BLACK BRITISH**		**OTHER ETHNIC GROUP**			
British		White/black Caribbean		Indian		Caribbean		Chinese			
Irish		White/black African		Pakistani		African		Other Ethnic group			
Any other white background		White/Asian		Bangladeshi		Any other black background		Prefer not to say			
		Any other mixed background		Any other Asian background							
Is there any particular language requirement or communication need? If yes, please specify:											

Family needs

To help with our assessment of the family's needs, please complete the following table. Please note that we do not operate a 'points' system. Families will be prioritised on the basis of need, as assessed with the family, rather than on how many categories are ticked on this form. The information you give here, together with the information provided by the family, will be used to plan the support we provide and to monitor how our support meets the family's needs.

SUPPORT NEEDS –		✓	**How might Home-Start help?**
1	Parenting needs including managing behaviour		
2	Being involved in the child(ren)'s development (school readiness)		
3	Coping with own physical health		
4	Coping with own mental health		
5	Coping with feeling isolated or loneliness		
6	Parent's self-esteem/mental health		
7	Coping with child's physical health		
8	Coping with child's emotional 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 or accessing community-based provision		
14	Other (please describe)		
15	Parents' own learning needs		

To provide as complete a picture as possible, please tick✓ any appropriate boxes

Drugs/alcohol abuse		Post Natal Depression		Other mental health issues		Violence/ Abuse	
Housing problems		Lone Parent		Sexual health need		Teenage pregnancy (<19)	
Child Disability		Child Learning Disability		Adult Disability		Adult Learning Disability	

Have you visited the family home?	YES/NO

Are there any issues which may compromise the health & safety of a visitor to the family home?

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

Thank you for taking the time to provide information which will help us to process this referral.

How to send a referral to Home-Start Kirklees: -

Health practitioners, please send referrals to home-start.kirklees@nhs.net
For professional referrals without an nhs.net account, return the completed form to: info@homestart-kirklees.org.uk (please password protect the document and call us to give the password).
Please note we do not accept professional referrals by post. For any queries, please telephone **01484 421925** or visit our website at www.homestart-kirklees.org.uk