**REFERRAL FORM (PROFESSIONALS)**

**INCREDIBLE YEARS (BABIES) PARENTING PROGRAMME**

**Details of person making request:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Agency:** |  |
| **Address:** |  |
| **Telephone:** |  |
| **Email Address:** |  |

**Please identify parent/s or child/children to be referred**

|  |  |  |
| --- | --- | --- |
| **Name:** | **Address:** | **Tel No/Email** |
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**Family Composition**

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| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Role** | **Address****(If different from above)** | **Current School** |
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| --- | --- | --- | --- |
| **Ethnicity:****Family’s First Language:****Interpreter Required (Yes/No)** |  | **SEN/Additional Needs of Child****SEN/Additional Needs of Parent/s** |  |
| **Other services/agencies** |  |

|  |  |  |
| --- | --- | --- |
| **Is the family currently open to Children’s Social Care?****(please tick which applies)****Name of Social Worker:** | **Yes** | **No** |
| **Does the family need support with travel costs?** **If ‘Yes’, please give brief details here:**  | **Yes** | **No** |

**Reason for request**

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| --- |
| Please provide relevant details on current family and home situation including relationship status of parents being referred. |
| Please state any known risks associated with the referred participants, i.e. substance misuse, domestic abuse. |
| 1) Please include if assessment/s are currently in place.2) Is this intervention part of a wider support plan?3) Please indicate if there are legal proceedings in place and any relevant court proceedings. |
| What issues would you like this programme to address?How will you determine if this has been achieved? |
| What does this family hope/want to achieve from this programme?. |

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| --- |
| Programme requested: INCREDIBLE BABIESPreferred date and venue (see schedule): |

**Data Protection**

The information provided on this form will be stored safely and securely in line with data protection guidelines.

I understand and agree that the information recorded on this form may be shared or stored with other children’s and family services.

**Signature of parent/carer Print Name:**

**Date on behalf of parent:**

**Please return the Parenting Request Form to:**

earlyhelpservice@gateshead.gov.uk

Early Help Service Team 1, Children and Families Support Service,

Care, Wellbeing & Learning,

Civic Centre, Regent Street, Gateshead NE8 1HH

(Tel. No. for queries 0191 433 3426)

**NOTES FOR REFERRAL AGENTS:-**

\*This Programme is for parents/carer and baby.

\*All babies must be under the age of 6 months at the start of the programme. The age range is not negotiable in order to protect the fidelity of the programme.

\*If this programme is to be included in a contact schedule, arrangements for ‘Greeting Contact’ of 20 minutes prior to the start of the session will need to be made.

 Note that this **will not** be supervised by programme facilitators.

\*Referrers are expected to ensure participants attend sessions weekly for the

 duration of the programme. This will include transport to and from the venue if

 necessary. It is important for participants to complete the full course. Allowance

 will be made for illness, however, it will not be a completed programme if 2 or more

 sessions or other exceptional circumstances are not attended. Parents should still

 attend, even if the child cannot attend due to illness/other circumstances..

\*Parents will be required to complete some tasks at home and use peer/buddy

 Support during the programme.

\*Please speak to course facilitators if you have any queries about a referral by

 contacting 0191 433 3426/2565.