

|  |
| --- |
| **Action for Children use only** |
| Child’s name |  | Date received by AfC |  |
| Parent’s name |  | Contact with referrer |  |
| Capita One ID |  | Date allocated to worker |  |
| e-Aspire Pin No  |  | CC Allocated Worker |  |

**Request for Targeted Children’s Centre Services (0-5yrs)**

**Please e-mail to Referrals.Northampton@actionforchildren.org.uk**

**or post to: Melanie Kilgour, Lead Practitioner, Doddridge Centre, 109 St James Road, St James, Northampton, NN5 5LD**

|  |
| --- |
| **1.Referring agency details (or own details if self referral)** |
| Name of Referrer (please write ‘Self’ if this is a self referral and go to section 2) |  |
| Date |  |
| Position (If applicable) |  |
| Agency Name (If applicable) |  |
| Address |  |
|  |
| Telephone Number  |  | Mobile: |  |
| E-mail Address |  |
| Has the parent/carer agreed to this request? | Yes / No | Can we contact the parent/carer directly? | Yes / No |
| Is the family registered with children’s centres? If not, please support them with their registration – see note in box belowYes / No | Yes/No |
| **Before submitting this referral please ensure the family is registered for Children’s Centre Services. A family can register in person at a library or children’s centre, or online via the Northamptonshire County Council website or by following the link below.** [*https://northamptonshire.firmstep.com/default.aspx/RenderForm/?F.Name=KbHeqBDhJtG#\_ga=1.153439032.1842977767.1468592195*](https://northamptonshire.firmstep.com/default.aspx/RenderForm/?F.Name=KbHeqBDhJtG#_ga=1.153439032.1842977767.1468592195) |

|  |
| --- |
| **2.Parent Details** |
|  | **First Name** | **Surname** | **Date of Birth** | **Gender** | **Disability (type)** | **Relationship to child(ren)** | **Ethnicity** |
| Main Carer |  |  |  |  |  |  |  |
| Additional Carer |  |  |  |  |  |  |  |
| Address  |  | Post Code  |  |
| Telephone No | Main Carer |  | Additional Carer |  |
| **3.Child(ren)’s details** |
|  | **First Name** | **Surname** | **Date of Birth/EDD** | **Gender** | **Disability (type)** | **Special Educational Needs** | **Ethnicity** |
| Child 1 |  |  |  |  |  |  |  |
| Child 2 |  |  |  |  |  |  |  |
| Child 3 |  |  |  |  |  |  |  |
| Unborn |  |  |  |  |  |  |  |
| Do all children live with the main carer? | YES / NO | If no, please provide details |

|  |
| --- |
| **4.Please indicate if any of the following apply** |
|  **EHA** |  **Child Protection** |  **Child in Need** |  **Looked After child/children** |
| **Additional information relating to the above: eg: date of assessment / plan, lead worker etc** |  |
| **5.Other Professional involved** |
| **Agency** | **Name** | **Contact number** | **email** |
| **Health Visitor name** |  |  |  |
| **Social Worker name** |  |  |  |
| **Other – please specify** |  |  |  |
| **Other – please specify** |  |  |  |
| **6. Are you aware of any issues/risks regarding worker safety that should be taken into account in planning our work? Please Specify** |
|  |
| **7.Brief Details of Family Circumstance** |
|  |
| **8. What do you want to see change for the family?**  |
|  |
| **9. Please indicate if you are requesting a specific service or programme?** |
|  Parenting 1:1  Family Partners intervention (Neglect) Peer Mentor (Home-Start volunteer) Financial / housing Steps – adult confidence building programme Support back into Employment / Training Other (please specify)  Parenting Programme Domestic Abuse Support **Thank you for completing this referral – please email completed requests to the address at the top of the form. We will send you an email to acknowledge receipt.**  |

|  |
| --- |
| **This Section is for Action For Children** **Office Use Only** |
| **Action for Children -Notes following contact with referrer** | **Date** | **Name** |
| **To be completed if referring to EBP Team – please ensure the full request for involvement form is included** |
|  |
| Cluster Family Support Worker |  | Mobile No |  |
| Cluster |  |
| Course Requested |  |
| Early Help Assessment uploaded to Capita (*if no, please state why*): |
| Name of parent(s)/carer(s) to attend course |
| Does/do the parent(s) have the ability to travel to venues? |
| Can childcare be arranged for the parent(s) to attend the course or is a crèche place required? |
| How can we contact the parent? |  Text Email Phone Letter Other (*please specify*) |
| It would greatly assist EBP Practitioners if you could give a brief history of the family circumstances and what children’s centre support the family have received to date: |
|  |