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| **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**

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| **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 below  Yes / 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) | | | | | | |

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| **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 | | | | | | | | | |

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| **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.** | | | |

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| **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: | | | | | |
|  | | | | | |