



Home-Start Richmond
Referral Form
Welcome Baby



Family No. \_\_\_\_\_
(For office use only)

Parkway House, Sheen Lane, East Sheen, SW14 8LS
Tel/Fax: 020 8487 8500 E-mail info@homestart-richmond.org.uk

WE ARE UNABLE TO PROCESS YOUR REFERRAL UNTIL WE RECEIVE THIS FORM

Please note that for the Welcome Baby Project, the expectant mother should be in the third trimester of pregnancy. If the child is new-born, please refer to our core service.

All referrals must be made with the consent of the family. This form will be held in confidence but may be shown to the family if requested.

Have you discussed this referral with the family prior to completing this form? YES \_\_ NO \_\_

Name of family \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Post Code \_\_\_\_\_

Tel No \_\_\_\_\_ Mobile No \_\_\_\_\_ Parent's signature \_\_\_\_\_ (optional)

Family needs

Please tell us if an interpreter is required for this family Yes \_\_\_ No \_\_\_

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. This information together with information provided by the family will be used to monitor how our support meets the family's needs.

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

Table with 3 columns: Family Needs, a checkmark column, and a text column for reasons. Rows include: 1. Preparing for the new baby, 2. Coping with own physical health, 3. Coping with own emotional health, 4. Coping with feeling isolated, 5. Parent's self esteem, 6. Managing the household budget, 7. The day-to-day running of the house, 8. Stress caused by conflict in the family, 9. Anticipating the extra work caused by multiple birth/multiple children under 5, 10. Use of services, 11. Other (please describe)

Please tell us about any Health and Safety issues that we need to consider when placing a volunteer with this family.

Have you visited the family home Y/N

Please tell us if the family has issues relating to (please circle)

Lone Parent Drug/Alcohol abuse Domestic violence Post-natal depression Mental Health Learning disabilities Teenage pregnancy (19 years or younger)

Please add any background information that you think we would find useful (if necessary attach an extra sheet).

Details of other members of the household with responsibility for caring for the children	Gender		Date Of Birth	Immigration Status		Considered to be Disabled by Main Carer?		Employed		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	Banladeshi	Other	Caribbean	African	Other	Chinese	Other	Any Mixed	British	Irish	Other																		
Main Carer (full name)																																								
Partner Living In Household (full name)																																								
Other (Please Specify e.g. Grandparent)																																								
Main Carer Sexual Orientation	Heterosexual			Bisexual			Gay/Lesbian				Rather not say/unknown																													
Details of Current Children (if any)  Please attach a separate sheet if necessary	Gender		Date Of Birth	Immigration Status		Considered to be Disabled by Main Carer?		On Child Protection 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	Banladeshi	Other	Caribbean	African	Other	Chinese	Other	Any Mixed	British	Irish	Other																		
1																																								
2																																								
3																																								
Details of any assessments for children's needs																																								
Name of Child				Subject to an assessment of needs such as CAF								Name and Agency of Lead Professional																												
				Yes				No																																
1																																								
2																																								
3																																								
Details of New Baby Please ✓ and give details where necessary				<table border="1"> <tr> <td>Single</td> <td></td> </tr> <tr> <td>Multiple</td> <td></td> </tr> <tr> <td>Planned Natural</td> <td></td> </tr> <tr> <td>Planned Caesarean</td> <td></td> </tr> </table>								Single		Multiple		Planned Natural		Planned Caesarean		<table border="1"> <tr> <td colspan="2">Birth Plan</td> </tr> <tr> <td>West Middlesex Hospital</td> <td></td> </tr> <tr> <td>Kingston Hospital</td> <td></td> </tr> <tr> <td>Other Hospital</td> <td></td> </tr> <tr> <td>Home Birth</td> <td></td> </tr> </table>											Birth Plan		West Middlesex Hospital		Kingston Hospital		Other Hospital		Home Birth	
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EDD																																								

<p><b>Referred by:</b></p> <p>Name _____</p> <p>Agency _____</p> <p>Address _____</p> <p>_____</p> <p>Tel _____</p> <p>Referrer's signature _____</p>	<p><b>Self-Referral:</b></p> <p>How did you hear about Home-Start: <u>(please tick)</u></p> <p>Website _____</p> <p>Family/Friend _____</p> <p>Midwife _____</p> <p>Health Visitor _____</p> <p>Social Worker _____</p> <p>Other _____</p>	<p><b>Family Doctor</b> _____</p> <p>Tel _____</p> <p><b>Midwife</b> _____</p> <p>Tel _____</p> <p><b>Health Visitor</b> _____</p> <p>Tel _____</p> <p><b>Other Agencies Involved</b> _____</p>
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