



# Families' House Referral Form

**Please note:**

It is difficult to process incomplete or unsigned forms so they may be returned

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Email: [admin@break-charity.org](mailto:admin@break-charity.org)

<b>REFERRING AGENCY/ Name of worker:</b>	<b>CONTACT ADDRESS:</b>
<b>TELEPHONE NUMBER:</b> <b>MOBILE NUMBER:</b>	<b>EMAIL:</b>

**CHILDREN IN HOUSEHOLD (use additional sheet if required)**

	CHILD 1	CHILD 2	CHILD 3	CHILD 4
NAME				
DATE OF BIRTH				
MOBILE/TELEPHONE/OTHER				
PREFERRED LANGUAGE				
NURSERY /SCHOOL/CHILD CENTRE/COLLEGE				

**CHILD INFORMATION**

PHYSICAL DISABILITY/GLOBAL DELAY								
CHRONIC/SEVERE ILLNESS								
SEN/LEARNING DISABILITY								
MENTAL HEALTH ANXIETY/SELF HARM								
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
LOW SELF-ESTEEM AND CONFIDENCE								
DO THEY HAVE CARE NEEDS								
CARING RESPONSIBILITIES								
MAIN CARER								
DO THEY CARE FOR MORE THAN ONE PERSON								
BEHAVIOURAL PROBLEMS								
OFFENDING/ ANTI- SOCIAL BEHAVIOUR								
SCHOOL ATTENDANCE ISSUES (NEET)								
IN WORK OR TRAINING								

**IF YOU HAVE TICKED ANY OF THE ABOVE, PLEASE GIVE FURTHER DETAILS:**

PARENTS OR GUARDIAN IN THE HOUSEHOLD	
NAME(s): D.O.B:	ADDRESS:  POST CODE:
TELEPHONE NUMBER: MOBILE NUMBER:	EMAIL:
PREFERRED LANGUAGE:	

OTHER SIGNIFICANT ADULTS (USE ADDITIONAL SHEET IF REQUIRED)	
NAME(s): D.O.B: RELATIONSHIP:	ADDRESS:  POST CODE:
TELEPHONE NUMBER: MOBILE NUMBER:	EMAIL:
PREFERRED LANGUAGE:	

PARENTS INFORMATION: (please tick boxes which apply)			
WHO HAS PARENTAL RESPONSIBILITY	FATHER	<input type="checkbox"/>	MOTHER
ARE BOTH PARENTS AWARE OF THE REFERRAL	YES	<input type="checkbox"/>	NO
IF NO INFORMATION IS BEING SUPPLIED REGARDING EITHER PARENT - PLEASE INDICATE WHY:			

PARENTS INFORMATION (Please tick all, boxes which apply)			
LEARNING DIFFICULTIES/SEN	<input type="checkbox"/>	PHYSICAL DISABILITY	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	DRUG ISSUES	<input type="checkbox"/>
MENTAL HEALTH DEPRESSION/SELF-HARMING/ANXIETY	<input type="checkbox"/>	ISOLATION/LONELINESS	<input type="checkbox"/>
LONE PARENT	<input type="checkbox"/>	PARENTING ISSUES	<input type="checkbox"/>
DOMESTIC ABUSE	<input type="checkbox"/>	BEREAVEMENT	<input type="checkbox"/>
HOUSING ISSUES	<input type="checkbox"/>	IN WORK/TRAINING	<input type="checkbox"/>
ASYLUM SEEKER/REFUGEE	<input type="checkbox"/>	ANTI-SOCIAL BEHAVIOUR	<input type="checkbox"/>
			CHRONIC/SEVERE ILLNESS
			ALCOHOL ISSUES
			TERMINAL ILLNESS
			LOW SELF-ESTEEM or CONFIDENCE
			PARENTAL CONFLICT SEPARATION ISSUES/CONTACT
			FINANCIAL ISSUES
			OTHER (Specify)

IF YOU HAVE TICKED ANY OF THE ABOVE, PLEASE GIVE FURTHER DETAILS:

ETHNICITY		RELIGION	
WHITE BRITISH		BANGLADESHI	C of E
IRISH		INDIAN	CATHOLICISM
WHITE EUROPEAN		PAKISTANI	SIKHISM
WHITE OTHER		CHINESE	ISLAM
BLACK BRITISH		MIXED WHITE ASIAN	JUDAISM
BLACK AFRICAN		MIXED WHITE AND BLACK AFRICAN	BUDDHISM
BLACK CARIBBEAN		OTHER (Specify)	NONE
GYPSY/TRAVELLER			OTHER (Specify)

ARE THERE ANY HEALTH & SAFETY RISK FACTORS FOR PROFESSIONALS/VOLUNTEERS OR FAMILY MEMBERS WHEN WORKING WITH THE FAMILY OR VISITING THE HOME?	YES	NO
IF YES, PLEASE GIVE DETAILS:		

IS THERE A FAMILY SUPPORT PLAN IN PLACE (FSP)	SAFEGUARDING / CHILD PROTECTION ISSUES (current position)	Currently Section 17 CIN (Child in Need) Currently section 47 CP (Child Protection)
PLEASE GIVE DETAILS:		
ANY OTHER AGENCIES OR INDIVIDUALS INVOLVED: (please give details):		
WHAT TYPE OF SUPPORT ARE YOU SEEKING:		
WILL YOU CONTINUE TO WORK WITH THE FAMILY AND FOR HOW LONG:		

CONSENT: Is the family or young person (12+) aware and in agreement with this referral	YES	NO
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FAMILIES' HOUSE USE ONLY				
Young Carer's	Separating Successfully Project	Time4Me	Family Support - School	
			Family Support - Families' House	
			DIG	
			Fun4Me	
			Volunteer Befriending Scheme	