

Referral Form

For Office Use Only

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| --- | --- | --- | --- |
| Date of Referral |  | Lead Worker |  |
| Referral Org. |  | Norpip Case No. |  |
| Area |  | Referral Code |  |
| Safeguarding status |  | Funder |  |

Section A to be completed by the referrer

|  |  |  |
| --- | --- | --- |
| **Family Information** |  | |
| Family Name |  |  |
| Birth Mother’s Name |  | D.O.B.: |
| Birth Father’s Name |  | D.O.B.: |
| Baby |  | DOB/EDD: |
| Siblings |  | DOB/Age: |
|  |  | DOB/Age: |
|  |  | DOB/Age: |
| Others co-resident |  | Mother Ethnicity: |
|  |  | Father Ethnicity: |
| Family Address |  | Infant Ethnicity: |
| Telephone/Mobile |  |  |
| Email |  |  |
| Social media |  |  |
| Preferred method of contact |  |  |

|  |  |  |
| --- | --- | --- |
| **Professionals Information** | Name | Contact Details |
| Midwife |  |  |
| Health Visitor |  |  |
| GP Surgery |  |  |
| Social Worker |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| Child in Need | Child Protection Plan | CAF |

|  |  |  |  |
| --- | --- | --- | --- |
| Ethnicity |  | Interpreter Required | Looked After Child |
| Disability Access Requirements |  | Family on Benefits |  |

**Clinical Information and Risk Factors**

|  |  |
| --- | --- |
| **Infant Vulnerabilities** |  |
| Failure to thrive / feeding concerns |  |
| Very Low birth weight / Premature |  |
| Diﬃcult infant temperament |  |
| Mother drank during pregnancy |  |
| Mother smoked during pregnancy |  |
| Prematurity |  |
| Congenital abnormalities / illness / serious developmental delay |  |
| Chronic maternal anxiety or stress during pregnancy |  |

|  |  |
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| **Parental Vulnerabilities and History** |  |
| Mental illness including anxiety or depression |  |
| Serious medical condition or disability |  |
| Learning diﬃculty or low educational achievement |  |
| Alcohol and/or substance misuse |  |
| Current domestic violence or abuse |  |
| Historical violence in the family |  |
| Significant bereavement |  |
| Poor or conflictual partner relationship between parents |  |
| Social isolation / lack of support structures |  |
| Chaotic lifestyle |  |
| Financial diﬃculties |  |

|  |  |
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| **Interaction and relationship Concerns** |  |
| Insensitive or inconsistent caregiving |  |
| Poor eye contact / avoidant infant behaviours |  |
| Lack of developmentally appropriate interactions |  |
| Caregiver does not enjoy the baby |  |
| Negative feelings towards the baby |  |
| Neglect or maltreatment (if yes please give details in referral) |  |

Section B to be completed with the parent(s)

|  |  |
| --- | --- |
| Summary of current concerns |  |
|  |  |
| Summary of reasons for this referral |  |
|  |  |
| Current or previous interventions |  |
|  |  |
| How would you like your relationship with your baby to be different? |  |

# Referrer Details

Name: Signature:

Role: Date:

Contact Number: Email:

# Parental consent:

I confirm that I consent to being referred to this support service or

I confirm on behalf of the parent that they have consented to this referral Date