**Family Support HUB**

**Network Referral Form**

***NB: REFERRAL TO BE FULLY COMPLETED AND IN BLOCK CAPITALS OR TYPED OTHERWISE FORM WILL BE RETURNED.***

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| **Coleraine/Moyle** |  |
| **Magherafelt/Cookstown** |  |
| **Antrim/Ballymena** |  |
| **Larne/Carrick/Newtownabbey** |  |

**Please indicate which Hub you are applying to:**

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| ***Referral Details*** |
| **Name of family or individual referred:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **Home Tel No:**  **Mobile Tel No:** |  |
| **Parent Email Address:** |  |

Please specify below which family member(s) require support:

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Information** | **Name** | **DOB** | **Requires Support (Y/N)** | **Ethnicity** | **Language Spoken** | **Disability /Health Issues** | **Parental Responsibility (Y/N)** |
| **Parent 1** |  |  |  |  |  |  |  |
| **Parent 2** |  |  |  |  |  |  |  |
| **Carer/Guardian** |  |  |  |  |  |  |  |

(Continue on a separate sheet if required)

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|  | **Name** | **DOB** | **Age** | **Gender** | **Requires Support (Y/N)** | **Ethnicity** | **Language Spoken** | **School Attended** | **Disability /Health Issues** |
| **Child/YP1** |  |  |  |  |  |  |  |  |  |
| **Child/YP2** |  |  |  |  |  |  |  |  |  |
| **Child/YP3** |  |  |  |  |  |  |  |  |  |
| **Child/YP4** |  |  |  |  |  |  |  |  |  |

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| Other Agencies Involved (currently or previously), e.g. G.P. Social Services, CAMHS, Education Welfare, other please specify;  **Name:**  **Agency: Contact details:** | | |
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| **Family Status:**  *(Please click on box to check)*  One parent family  Gender: Female  Male  Other  Please state …………..  Two parent family | **Family Composition:**  *(Please click on box to check)*  Home (both parents)  Home (one parent + partner)  Home (one parent)  Unknown  Kinship Carer/s  (please specify e.g. Grandparent) ………………………………… |

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| ***Primary Reason for Referral***  ***(****Please check* ***one box*** *only)* |  |
| Adult mental health issues | Bereavement support (adult) |
| Bereavement support (child) | Child care support |
| Counselling services for children/young people | Counselling services for parent/s |
| Counselling services for families | Disability support |
| Domestic violence | Drug/alcohol related harm/abuse by child or young person (0-18) |
| Drug/alcohol related harm/abuse by adults (including parents) | Education and employment support |
| Emotional and behavioural difficulty support for pre-school children | Emotional and behavioural difficulty support for primary school children |
| Emotional and behavioural difficulty support for post primary school children | Emotional and behavioural difficulty support for parents |
| Emotional support for child (bullying, separation etc) | Family breakdown |
| Financial support | Housing |
| Homelessness | Offending (at risk behaviour) for children and young people |
| Parenting programmes/parenting support | Practical support e.g. furniture/appliances |
| School attendance | Self-harming (child) |
| Youth activities/support | One to one support for young people |
| Other – please state |  |

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| **Reason for Referral (Current concerns / issues:** |
| **Type of Service / Programmes Requested:** |

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| **Confirmation of Consent:** PLEASE READ CAREFULLY THROUGH COMPLETED FORM BELOW BEFORE SIGNING | |
| * I have read and understood the Family Support Hub Information Leaflet. * I consent to myself/my family/my child (delete as appropriate) being referred to the Family Support Hub and on to an appropriate service provider. * I understand and agree with the information provided and the referral to the Family Support Hub. * I understand that a further needs assessment may be required in consultation with myself, in order to identify service(s) required. * I understand that in order to access an appropriate service there will be a need to share information about myself or my family with Hub Members, however this will be on an agreed ‘need to know’ basis.   \*Signed …………………………………………………. (Parent/Person with Parental Responsibility/Individual)  Date ……………………………  **\*Referral Forms will only be accepted with either signature or dated confirmation that verbal consent has been given.** | |
| **Referred By:** | **Contact Details:** |
| Name:  Agency:  Date: | Address:  Postcode:  Tel. No:  Email: |
| Signed: ………………………………………………… (Referrer) Date: ………………………. | |