



**Referral Form For Home-Start Community Worker**

**Little Hands Children's Centre**



**Home-Start  
Canterbury & Coastal**

Little Hands Children's Centre  
Hollowmede  
Canterbury  
Kent, CT1 3ST  
Phone: 01227 457087  
Fax: 01227 457108

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

*Please note that all referrals must be made with the consent of the family. Home-Start will seek the ongoing consent of the family as our support continues.*

**Home-Start Family number (Home-Start Official use only) \_\_\_\_\_**

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

**This form will be held in confidence but may be shown to the family if requested.**

We try to respond to all referrers within 2 weeks after receiving the referral to report progress. If you have any issues or concerns about the referral process or the support for the family please contact the office.

Date: \_\_\_\_\_

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

Address \_\_\_\_\_

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

Tel No. \_\_\_\_\_ Mobile. \_\_\_\_\_

Name of mother/partner \_\_\_\_\_ Main carer YES/NO

Name of father/partner \_\_\_\_\_ Main carer YES/NO

Main Carer: d.o.b. \_\_\_\_\_ Main Carer: Male \_\_\_ Female \_\_\_ Lone Parent: Yes \_\_\_ No \_\_\_

***Please note the family must have at least one child under the age of five years.***

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

<b>Referred by:</b> Name _____ Self _____ Agency _____ Address _____ _____ _____ Tel _____	<b>Family Doctor</b> _____ Tel _____ <b>Health Visitor</b> _____ Tel _____ <b>Other Agencies involved</b> _____ _____
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**Please complete this form and return it to: Little Hands Children's Centre, Hollowmede, Canterbury, Kent, CT1 3SD. Phone: 01227 457087 Fax: 01227457102 Email: LittleHandsCC@kent.gov.uk**

## Family needs

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:

	✓	<i>If you have ticked, please tell us why this is a need and how a volunteer might be able to help</i>
1. Feeling isolated		
2. Using other services/facilities in the area		
3. Parent(s) emotional health/well-being		
4. Parent(s) self-esteem		
5. Parent(s) physical health/well-being		
6. Child(ren)'s physical health/well-being		
7. Child(ren)'s emotional health/well-being		
8. Managing the child(ren)'s behaviour		
9. Being involved in the child(ren)'s development		
10. Stress caused by conflict in the family		
11. The day-to-day running of the house		
12. Managing the household budget		
13. Coping with the extra work caused by multiple birth/multiple children under 5		
14. Other (please describe)		

Please tell us about any Health and Safety issues that we need to consider when placing a volunteer with this family. i.e. domestic violence or large animals?

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

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### Details of main carer & other members of the household with responsibilities for caring for the children

	Gender		Date of birth	Immigration status		Do they consider themselves to be disabled?		Asian or Asian British				Black or Black British			Chinese or Other Ethnic Grp		Mixed	White		
	Male	Female		Asylum seeker	Refugee	YES	NO	Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese	Other Ethnic		Any mixed	British	Irish
Main Carer																				
Partner living in household																				
Other Please specify e.g. Grandparent																				

**Thank you for taking time to provide this information which will help us to process the referral.** We will try to respond to you within 2 weeks to tell you about progress with this referral.

**For Office use only**

Family to be offered (please tick):

Home visiting by volunteers

Group support

A combination of the two


Has this family received Home-Start support previously? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes when did the Home-Start support cease Date\_\_\_\_\_

Support to start on (date) \_\_\_\_\_

Support ceased on (date) \_\_\_\_\_