|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Information** | | | | | | |
| Parent(s) Name: | | | D.O.B: | NHS Number (if required): | | |
| Ethnicity: | | | | Religion: | Gender: | Sexuality: |
| Baby’s Name: | | | DOB/EDD: | NHS Number (if required): | | |
| Ethnicity: | | | Religion: | | Gender: | |
| Siblings: |  | | | DOB: | | |
|  | | | DOB: | | |
|  | | | DOB: | | |
| Family Address:  Postcode: | |  | | | | |
| Home Telephone: |  | | | Mobile: |  | |
| Email: |  | | | | | |

**FAMILY ACTION SOUTH TEES PERINATAL SUPPORT SERVICE REFERRAL FORM**

|  |  |  |
| --- | --- | --- |
| **Professionals Involved Information** | **Name** | **Contact Details** |
| Midwife |  |  |
| Health Visitor |  |  |
| Social Worker |  |  |
| Other key professional (s) |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Child in Need | Child Protection Plan | Early Help Assessment | Looked After Child |
| Interpreter Required  (Specify language): | | | |
| Disability / Access Requirements: | | | |
| Are there any known risks to workers undertaking visits at the family home?  If you have completed a risk assessment and have consent to share please attach a copy. | | | |
| Are there any child or adult safeguarding issues that we need to be aware of? | | | |

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| --- | --- |
| **Making a Referral**  We have found that service users are more likely to take up our service if they fully understand the support that we can offer, below is a brief summary of the service offer. Please share this with the person who is considering being referred and then complete the reasons for making a referral section. A service leaflet is also available to be shared with families in advance of referral.  **Practitioner Support:** is provided by a trained staff member who will complete an initial assessment and work with parents to develop a supportive package to help reduce feelings of isolation, loneliness, and low mood. Practitioners can also support parents to improve attachment with their baby and access local services.  **Group Work**: therapeutically informed attachment-based group work programme, delivered over a minimum of 6 sessions by trained professionals. Providing parents with opportunities to try simple fun games and play activities that can help build strong relationships with their baby, and also build social networks by meeting other parents with babies. | |
| **Reasons for referral** | **Please tick all that apply** |
| Maternal Mental Health |  |
| Paternal Mental Health |  |
| Social Isolation |  |
| Attachment & Bonding |  |
| Group Work |  |

|  |  |
| --- | --- |
| **Reasons for making this referral:**  Why would this parent benefit from practitioner support and/ or group work?  What changes do the family want to make with support from the service?  Are there any barriers we need to be aware of which may prevent the family from engaging or achieving outcomes?  What else might you need to tell us?  Are there any concerns/risks within the family you have not already mentioned? \*If you are a Health Visitor or Midwife making this referral please include GAD-7 & PHQ-9 scores.Please note our service is aimed at parents experiencing low – moderate maternal/paternal mental health issues. |  |

# Referrer Details

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|  |
|  |

Name: Signature:

Role: Telephone:

Date: 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

**Consent to process relevant data:**

I confirm on behalf of the parent that consent has been given for data relevant to their referral to the Perinatal Support Service to be processed and stored by Family Action

|  |
| --- |
|  |

Date

**Please return via email to:** [Southteesperinatal@family-action.org.uk](mailto:Southteesperinatal@family-action.org.uk)

For office use only:

|  |  |  |  |
| --- | --- | --- | --- |
| Date received |  | Allocated Worker |  |
| Date accepted |  | . |  |
| Level of concern RAG : |  |  |  |
| Postcode checked |  |  |  |