**NOW Family Service criteria:**

* **Support families if a parent self identifies or has a diagnosis of a learning disability, learning difficulty, autism or neuro diverse condition.**
* **The parent is pregnant or has a child at home under 5**
* **With no or low social work involvement**

**Send referral password protected to** [**michele.muldoon@nowgroup.org**](http://?) **or call Michele 07719518462**

**REFERRAL FORM**

**CONTACT DETAILS:**

|  |  |
| --- | --- |
| NAME: | DATE OF BIRTH: |
| ADDRESS: | |
| POSTCODE: | CONTACT NUMBER: |
| PARENT CONDITION: | |

**NEXT OF KIN DETAILS**

|  |  |
| --- | --- |
| NAME: | RELATIONSHIP: |
| ADDRESS: | |
| POSTCODE: | CONTACT NUMBER: |

**FAMILY INFORMATION**

|  |  |
| --- | --- |
| CHILD 1: DOB: | CHILD 2: DOB: |
| CHILD 3: DOB: | CHILD 4: DOB: |
| DOES ANY OF THE CHILDREN HAVE ADDITIONAL NEEDS: | |
|  | |
|  | |
| DOES THE FAMILY HAVE SOCIAL SERVICES INVOLVEMENT: | |
|  | |
| PARTNER PRESENT: | |
|  | |

**REFERRERS INFORMATION:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SELF REFERRAL |  | SOCIAL WORK REFERRAL | |  | OTHER *(please state)...* |  |
|  | | | | | | |
| Referral Agent : | | | Key Worker/Advisor: | | | |
| Address: | | | | | | |
| Contact Number: | | | | | | |

**HOW DID YOU HEAR ABOUT US?**

|  |  |  |  |
| --- | --- | --- | --- |
| Poster (Where?) |  | Radio |  |
| Newspaper (Which?) |  | Black Taxi |  |
| Social Media (Which?) |  | Other? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| SIGNED:  *(Client)* |  | DATE: |  |

**OUTCOME OF CRITERIA MEETING (NOW Group Staff to complete)**

|  |
| --- |
|  |

|  |
| --- |
|  |

**KEY WORKER ASSIGNED**

|  |  |  |  |
| --- | --- | --- | --- |
| SIGNED:  *(Programme Lead)* |  | DATE: |  |