Family Support HUB
Network Referral Form

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

Please indicate which Hub you are applying to:

COLERAINE/MOYLE	
MAGHERAFELT/COOKSTOWN	
ANTRIM/BALLYMENA	
LARNE/CARRICK/NEWTOWNABBEY	

Referral Details	
Name of family or individual referred:	
Address:	
Postcode:	
Home Tel No: **Mobile Tel No:**	
Parent Email Address:	
GP name and address:	

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

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)

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

Other Agencies Involved (currently or previously), e.g. G.P. Social Services, CAMHS, Education Welfare, other please specify;

Name:	**Agency:**	**Contact details:**

Please return your completed form to:

Family Support Hubs - Email: familysupporthubs@actionforchildren.org.uk Tel: 028 94467345
Or send completed application form to: Action for Children, Family Support Hubs, 4A Steeple Road, Antrim, BT41 1AF.

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) ……

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:

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: ……	

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