South Eastern Health and Social Care Trust

REFERRAL TO FAMILY SUPPORT HUB

Referral to be fully completed and in block capitals or typed otherwise form will be returned

Please indicate which Hub you are applying to:

Ards & North Down	
Down	
Greater Lisburn	

Family Name:	Date:
Address**:** Telephone**:**	
<u>Parent/Carer/Partner</u> Name: Date of birth: Employment Status: Marital Status:	<u>Parent/Carer/Partner</u> Name: Date of birth: Employment Status: Marital Status:

<u>Children</u> *

	Name	Gender	DOB	Age	School
1					
2					
3					
4					

Ethnic Origin Parent/s:

Ethnic Origin Child/Children:

GP Name and Address:

Do you consider parent or child to have a disability?

Yes ☐ No

If 'yes', please specify:	Parent		Child
	☐	Physical	☐
	☐	Learning	☐
	☐	Sensory	☐
	☐	ASD	☐
	☐	ADHD/ADD	☐
	☐	Other	☐

* continue on separate sheet if necessary

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Referrer Details: (to include contact details ie phone number and email address):
Reason for referral: (needs identified)
Type of support required: (specific recommendations)
What outcomes are you expecting to achieve from this support?
What other organisations/home based supports are currently supporting the child/family? Please specify
Has the Family previously received a service from the Hub? Yes ☐ No ☐ Unaware/Don't know ☐
Family **MUST** consent to referral and for information to be shared with Hub Members by signature below. Signed:
Referrer Signature:

Completed applications to;
Family Support Co-ordinator, Laganside House, Lagan Valley Hospital, 39 Hillsborough Road, Lisburn BT281JP. 02892501357. familysupporthubs@setrust.hscni.net

For further information on how the Trust processes personal data please visit:
http://www.setrust.hscni.net/about/DataProtection.htm