Believe in children
Barnardo's Northern Ireland

Western Locality

Referral Form

Service:	Operating location
Strabane Family Support Hub	West

Address: Strabane Family Support Hub
2A Melmount Road,
Strabane,
Co Tyrone
BT82 9BT

Telephone: 02871382658/07809100511

Referral e-mail: shauna.devine@barnardos.org.uk

Barnardo's has an Open Access policy and if requested will share information contained in this form with the referred child and their family. Should you wish to discuss this further speak to the contact person of the referral service.

Please remember to enclose copies of any relevant background reports, where available. Referral forms must have been discussed with the parent and allocated social worker (if applicable) prior to submission.

Referrer Information

Referrer Name		Date of referral	
Relationship to Family			
Contact Details (Telephone/Email)			

Family Composition

*(Please include **ALL** members of immediate family in the table below - highlighting the member/s of the family requiring support. **Please add contact details for parents/carers**.*

Name	**CONTACT DETAILS** **Address/Telephone/ Email** **Post code required**	DOB	Gender Identity	Religion	Relationship within family	Ethnicity	Disability
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.
			Please select	Choose an item.		Choose an item.	Choose an item.

Please indicate the member/s of the family listed above that you consider to need support from Barnardo's

Please indicate any health conditions/issues for any members of the family
Please give GP name/address

Other Significant Persons

Name	Address / Tel No	DOB	Gender Identity	Relationship to family	Relevant information
			Please select		
			Please select		
			Please select		
			Please select		

Agencies/Professionals currently or previously involved with the family (including Education, Nursery, Medical Professionals)
(Excluding Social Work – see next section)

Agency	Contact Information	Purpose and intensity of involvement (With dates)

Legal/Data Protection

Is child known to Social Work and do they have current Social Worker? *(If Yes, give details)*	Yes ☐ No ☐
Is child/ren on Child Protection Register or have they historically been?	Yes ☐ No ☐

(If Yes, give details incl reason for Registration and dates)	
Were child/children previously subject of a Child Protection Case Conference or Case Discussion?	
Is Child/ren subject to any Legal Orders, e.g. Looked After and/or Accommodated? *(If Yes, give details including section of Children (NI) Order statutory involvement is authorised under)*	Yes ☐ No ☐
Do child/ren have any special educational needs? *(If Yes, give details)*	Yes ☐ No ☐
Do any of the family have any specific needs related to their Health, Disability or Ethnicity? *(If Yes, give details)*	Yes ☐ No ☐

Background Information

Information provided here will assist with the allocation of the most appropriate service. Please include dates where possible. **If available, please attach the most recent report/s with the referral form.**

Brief Family History *Please include periods of separation (death of parent, foster care, kinship etc.)*	
Reason for Referral	

What differences /changes (outcomes) would you like to see as a result of support offered?	
Can you tell us about any strengths existing within the family/individual which will support in achieving these outcomes?	
Areas of Family Tension/Difficulties - Please include any history of Domestic Abuse, Alcohol/Drug misuse/dependence	

This section should be completed by the Parent/Carer or subject:

How do you think Strabane Family Support Hub can help you/your family?	
What apprehensions/fears do you have about being referred to Strabane Family Support Hub?	

Consents

Is family aware that referral has been made?	Yes ☐	No ☐
Is family in support of the referral?	Yes ☐	No ☐

	If not, please comment:
Has the named person been informed?	Yes ☐ No ☐
Have they consented to the referral?	Yes ☐ No ☐

Risk

Are there any risks to practitioners in relation to working with this family? Yes ☐ No ☐

Signatures

We take this opportunity to request your consent to keep records of our contacts with you and key information relating to the work we do with you and your family. By signing below, you are indicating that you are in agreement that the content of this referral is accurate, and you authorise Barnardo's to store this information on their secure system. We take great care in keeping this information confidential. Barnardo's have an open access policy which means you have a right to see your file. If you wish to access your file, please contact any member of staff who will arrange for the Service manager to discuss the details with you.

Referrer:
This referral will be considered at an allocation meeting, where referrals are discussed and prioritised. You will be contacted after the meeting with regards to the outcome of this referral.

Signed (Referrer) _____ Date _____

Designation _____

Parent(s)/Carer(s): Where possible please get the parent to sign the referral.
This referral will be considered at an allocation meeting, where referrals are discussed and prioritised. By signing this form, you are agreeing for Strabane Family Centre to contact you.

Signed (Parent/Carer) _____ Date _____

Signed (Parent/Carer) _____ Date _____

Further Information

The following information is required for reporting of statistics to Barnardo's

Service User Issues (Tick 1 only)		**Generic reason for referral** (Tick up to 4)			
☐	Alcohol or Substance Misuse	☐	Abuse	☐	Neglect

☐	Anti-Social or Criminal behaviour	☐	Alcohol or Substance Misuse	☐	Not in employment, education or training
☐	Care Leaver	☐	Anti-Social or Criminal behaviour	☐	Nutrition/Healthy Living
☐	Disability	☐	Bereavement	☐	Parent in criminal justice system
☐	Family Member	☐	Bullying, Discrimination, Harassment	☐	Parent/family illness
☐	Homelessness	☐	Communication/Language development	☐	Physical abuse
☐	Looked After Children	☐	Debt and money management	☐	Poverty
☐	Missing	☐	Domestic violence	☐	Relationship issues
☐	Parent or Carer	☐	Emotional abuse	☐	Self-harm
☐	Person isolated from community	☐	Emotional & Behavioural wellbeing	☐	Self-esteem / resilience
☐	Poverty	☐	Exclusion	☐	Sexual abuse
☐	Sexual Exploitation	☐	Fuel Poverty	☐	Sexual exploitation
☐	Student or Trainee	☐	Parenting	☐	Sexual health or behaviour
☐	Violence, abuse or neglect	☐	Homelessness	☐	Teenage pregnancy
☐	Vulnerable person needing support	☐	Housing	☐	Trafficking
☐	Young Carer	☐	Learning Difficulty	☐	Truancy
		☐	Life threatening & limited illness	☐	Violence abuse and neglect
		☐	Mental Health	☐	No presenting issues

For Office Use:
<u>Outcome of referral</u>

Service Offered		Date
Service Offer Accepted?	Yes ☐ No ☐ If no – reason:	Date
Allocated Worker		Date
Initial home visit/ assessment	Worker(s):	Date