Family Support Hub Referral Form

Reference Number: ..... **Date Received:** .....
(For Office Use Only)

Referral Details	
Name of family or individual referred:	
Address	
Postcode	
Tel No	

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

Family Information	Name	Date of Birth	Requires Support (Y/N)	Ethnicity	Language Spoken	Disability/Health Issues
Parent 1						
Parent 2						
Carer/Guardian						

(Continue on a separate sheet if required)

	Name	Date of Birth	Requires Support (Y/N)	Ethnicity	Language Spoken	School Attended	Disability/Health Issues Please Outline
Child/YP1							
Child/YP2							
Child/YP3							
Child/YP4							

Are there any barriers to communication? For example, language, sensory impairment, disability, etc? Yes / No
If yes, please specify.

Other Agencies Involved	Contact Details
G.P.	

Reason for Referral (Continue on separate sheet if required)
Type of Service/Programme Requested

Has the family/individual previously engaged with a Family Support Hub? (Yes / No)
If Yes, please specify area and date?

Confirmation of Consent: **PLEASE READ CAREFULLY THROUGH COMPLETED FORM 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 ……

Referred By:	**Contact Details**
Name: **Agency:** **Date:**	**Address:** **Post code:** **Tel. No:** **Email:**
Additional Information:	
Signed …… (Referrer) **Date** ……	

***Referral Forms will not be accepted without signature to confirm consent.**

Referrals submitted electronically will not be accepted.

Family Support Hub Referral Record

For office use only (Hub Lead Body)

Referral Form Identifier Number:	**Date Referral Received:**
Previously Referred to Hub: Y/N	**Date Referred:**
Date Of Initial Contact:	**Electoral Ward:** **SOA:**
Service Unavailable: Y/N	**Family Assessment Required: Y/N** **By Whom:**
Referred To: **Date:**	**Service Declined: Y/N**

Decision made by the Family Support Hub	
Accepted and Signposted	
Signposted but family did not engage	
Rejected assessed as at Tier 3	
Rejected for other reason **(Please Specify)**	
Unable to meet need of referred family	
Returned to Gateway	
Services Attended	
Number of children/parent referred on who took up the service offer	
Number of children/parent referred on who did not take up the service offer	
Programmes Completed	
Number who completed the intervention referred to	
Number who did not complete the intervention referred to	
Outcomes of Service Intervention	
Number who completed the intervention referred to with positive outcome	
Number who completed the intervention referred to with no positive outcome	

Hub Co-ordinator Signature ……

Date ……