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| **FAMILY SERVICES SELF-REFERRAL FORM** |

**For more information please contact us on:**

**Telephone:** 02074241601

**Email:** referrals@elfridacamden.org.uk

**Website:** www.elfridacamden.org.uk

**evi@elfridacamden.org.uk**

Due to high demands of referrals into the family services you may be placed on a waiting list. The parent on the form will be contacted within 2 weeks of the submission of the referral form.

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| **Name of referrer:**  **Date Received:** | | |
| 1. **ELIGIBILITY CRITERIA**   Please check that you can tick yes to **all** of the questions 1 – 3 below before you make a referral. | | **YES** |
| **1** | **You have children between 0-18 years old AND living in Camden?** |  |
| **2** | **There are no other key workers, social workers or lead professionals providing intensive support to the whole family** |  |
| **3** | **There are family support needs** |  |
| **4** | **The child/ren in the family have or have experienced;** Please tick all that apply |  |
|  | Behavioral problems |  |
| Emotional or mental health difficulties or at risk of deterioration of mental health |  |
| Victim of bullying, isolation or damaging family relationships |  |
| Disability, long-term health problem, or special educational needs |  |
| **5** | **The parents/guardian in the family can be described as having the following;** Please tick all that apply |  |
|  | Long-term or currently unemployed |  |
| Having a disability/learning difficulties/long-term mental or physical illness |  |
| Homeless, threatened with homelessness, or living in overcrowded housing |  |
| Single parent or recently separated families |  |
| Newly arrived in UK |  |
| Refugee, traveller and black/ethnic minority communities |  |
| Experiencing or past drug and alcohol abuse |  |
| Experiencing or past domestic violence |  |
| Struggling with mental health difficulties |  |
| Difficulties with finances |  |
| Have children with behavioral problems |  |
| **Please note** that we will not take referrals where we believe there is a need for statutory assessment, monitoring or casework where we think there are ongoing safeguarding concerns or risks or where children may be suffering or at risk of suffering significant harm (based on current *thresholds criteria for Children’s Services* – LB of Camden).  We will carry out a **risk assessment** for all referrals received including requesting information from referrers. All casework will be conducted in accordance with those risk assessments and controls identified as well as ERC protocols for staff safety. | | |

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| FAMILY DETAILS | | | | | | | | | |
| PARENT/GUARDIAN | | | | | | | | | |
| Parent/Guardian’s Surname: | | | First Name: | | | | | | |
| Date of Birth: | | | | | | | | | |
| Address: Postcode: | | | | | | | | | |
| Telephone (Home): | | | Mobile: | | | | | | |
| Language(s) Spoken: | | | Ethnicity: | | | | | | |
| **CHILDREN** | | | | | | | | | |
|  | **First Name** | **Surname** | | **Date of Birth** | | | | **Gender** | |
| **Eldest Child** |  |  | |  | | | |  | |
| **Child 2** |  |  | |  | | | |  | |
| **Child 3** |  |  | |  | | | |  | |
| **Child 4** |  |  | |  | | | |  | |
| **Child 5** |  |  | |  | | | |  | |
| **Language(s) Spoken:** | | | | | | | | | |
| **Ethnicity(ies):** | | | | | | | | | |
| **Any disabilities or support needs:** | | | | | | | | | |
| 1. **REFERRAL DETAILS** | | | | | | | | | |
| What is the reason for the referral? (Please include any strengths that the family has or concerns.) | | | | | | | | | |
| **Is there any other support that you think that would benefit the family?** | | | | | | | | | |
| 1. **PERMISSION** | | | | | | | | | |
| **Do you give permission to be contacted by a Support worker at Elfrida Rathbone?** | | | | | **Yes** |  | **No** | |  |
| **Signature:** **Date:** | | | | | | | | | |