**Family Lives Referral Form**

Please note that all referrals must be made with the consent of the family. Have you discussed this referral with the family and obtained their consent to make the referral? Yes ☐ No ☐

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FAMILY DETAILS** | | | | | |
|  | **First name** | **Family Name** | | **Child DOB** | |
| **Parent/Carer 1** |  |  | |  | |
| **Parent/Carer 2** |  |  | |  | |
| **Child 1** |  |  | |  | |
| **Child 2** |  |  | |  | |
| **Child 3** |  |  | |  | |
| **Child 4** |  |  | |  | |
| **Tele** | | **Is it OK to leave a message:** Yes ¨ No ¨ | | | |
| **Email** | | **Address inc. post code** | | | |
| **Which child is this course applicable to?**  **Reason for referral:**  **What do you want the attendee to gain from this course?/What do you want to gain from this course?** | | | | | |
| **Are there any SEN?** Yes ¨ No ¨  If yes, please specify condition  **Is there a FFA in place?** Yes ¨ No ¨  **Is there a CiN in place?** Yes ¨ No ¨  **Is there a CP in place?** Yes ¨ No ¨  **Is there a Parenting Order in place?** Yes ¨ No ¨ | | | | | |
| **Does the attendee have any access needs?** Yes ¨ No ¨  If yes, please specify the needs  **Is an interpreter required?** Yes ¨ No ¨  If yes, please specify the language | | | | | |
| **COURSE INFORMATION** (Online groups delivered through MS Teams)  **Bringing up confident children for parents of children with ADHD/ASD (6 weeks)** ¨  Thursday 15th September to 20th October, 9.30 – 11.30  **Getting on with your Pre teens/Teens (6 weeks)** ¨  Thursday evening 6th October to 17th November 7.00pm - 9.00pm  **Bringing up confident children for parents of children with ADHD/ASD (6 weeks)** ¨  Tuesday 4th October to 15th November, 9.30-11.30  **Bringing up confident children for parents of children with ADHD/ASD (6 weeks)** ¨  Wednesday 9th November to 14th December, 9.30 – 11.30  **Bringing up confident children for parents of children with ADHD/ASD (6 weeks)** ¨  Tues 8th November to 13th December 7.30pm – 9.30pm | | | | | |
| **REFERRER DETAILS** | | | | | |
| **SELF-REFERRAL (*Please specify how you found out about the course)*** | | | | | |
| **PROFESSIONAL REFERRAL**  **Name Date of Referral**  **Role** | | | | | |
| **Email** | | | | **Tele** | |
| **Agency**  **DSPL   (specify which area)**  **Family Centre   (specify which)**  **Health (specify)**  **Intensive Family Support**  **Integrated Services for Learning**  **Pathway Provider**  **Probation**  **SFW/School**  **Social Care**  **SASH**  **Other (please specify)** | | | | | |
| The parenting group is funded by Herts County Council. They would like to contact the parent after the group to gain their feedback via a short survey. The purpose of this survey is to ensure that HCC are providing the right kind of support to families and their assistance with this is greatly appreciated  Please confirm if the parent has given consent for us to give their email address to the council. Yes ¨ No ¨ | | | | | |

**SERVICE INFORMATION**

Our programmes are delivered by trained and accredited practitioners. The programmes aim to help parents learn how to communicate positively, to value their own needs, to help them recognise the importance of children’s feelings and needs and how to acknowledge these needs.

Details on this form will be kept strictly confidential within Family Lives and will only be used to work with clients and for our evaluation systems.

**Please return the form password-protected to:** [**services@familylives.org.uk**](mailto:services@familylives.org.uk)**, sending the password in a separate email**

**Call 0204 522 8700 or 8701 for further information**

**FOR OFFICE USE ONLY**

**Date Received:**