

**Helping Hands Referral Form**

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| **Referrer’s Name**   | **Job Title:**  |
| **Agency:**  |  **Date of Referral :** |
| **Agency Address:**  |
| **Postcode:**  | **CIS No if applicable:** |
| **Client Name:**  | **Client Tel. No :**  |
| **Client’s Address:** **Postcode:** | **Client D.O.B** | **SAFE TO WRITE****YES/NO** |
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| **Currently in relationship Yes / No** |
| **Perpetrators Name & DOB if known** |  |
| **CHILD/CHILDREN for referral** |
| **NAME** | **School**  | **Contact** | **Telephone** | **School Year** | **Key Stage** |
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| **GP: Surgery:** |
| **Telephone:** |
| **AUTHORISATION TO CONTACT IF REQUIRED** **SCHOOL YES/NO DOCTOR YES/NO AGENCY REF YES /NO** |

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| **Areas of Concern:****Health Issues (include allergies/food intolerances, illnesses, epilepsy, asthma)** |
| **Brief Outline Of Family History (please include who the CYP lives with)** |
| **Any Other Concerns or Information That You Feel Would Be Useful For Me To Know** **(please include experience of Domestic Abuse)** |
| **I Do/Do not agree for my CYP to attend the Helping Hands Programme****Name of Parent/Main Carer: ……………………………………………………..****Sign: ………………..................... Date: ……………………………….** |

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|  Date called | Outcome |  | Offered | Outcome |
| 1st call |  |  |  |  |
| 2nd call |  |  |  |  |
| 3rd call |  |  |  |  |
| 4th call |  |  |  |  |

Please Return the completed referral form to Victoria.Williams@SanctuaryHousing.co.uk Telephone: 01803 698878