

**Referral Form**

For Office Use Only

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Referral |  | Lead Worker |  |
| Referral Org. |  | Norpip Case No. |  |
| Area |  | Referral Code |  |
| Safeguarding status |  | Funder |  |

**Section A**

**Requesting*:(Please Tick):*  Parent Infant Psychotherapy**   **Perinatal Support\***  **Antenatal classes\***

\*=only available to families in NN1-NN5 and NN11

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family Information** |  | | | |
| Birth Mother’s Name: |  | | DOB.: | |
| Birth Father’s Name: |  | | DOB.: | |
| Baby’s name: |  | | DOB/EDD: | |
| Siblings: |  | | DOB/Ethnicity: | |
|  | | DOB/Ethnicity: | |
|  | | DOB/Ethnicity: | |
| Family Address: |  | | Mother Ethnicity: | |
| Father Ethnicity: | |
| Infant Ethnicity: | |
| Others co-resident: |  | | Are the family able to drive? | |
| Telephone/Mobile |  | | | Please tick next to the preferred method of contact. |
| Email |  | | |
| Can we leave a message on your phone? Yes / No | | Can we text you? Yes / No | | |

|  |  |  |
| --- | --- | --- |
| **Professionals Information** | Name | Contact Details |
| Midwife |  |  |
| Health Visitor |  |  |
| GP Name |  |  |
| Social Worker |  |  |
| Other |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Child in Need | Child Protection Plan | Early Help Assessment | Looked After Child |
| Family on Benefits | Interpreter Required  (Specify language): | | |
| Disability Access Requirements: | | | |

**Clinical Information and Risk Factors**

|  |  |
| --- | --- |
| **Infant Vulnerabilities** |  |
| Failure to thrive / feeding concerns |  |
| Very Low birth weight / Premature |  |
| Diﬃcult infant temperament |  |
| Mother drank alcohol during pregnancy |  |
| Mother smoked during pregnancy |  |
| Prematurity |  |
| Congenital abnormalities / illness / serious developmental delay |  |
| Chronic maternal anxiety or stress during pregnancy |  |

|  |  |  |
| --- | --- | --- |
| **Parental Vulnerabilities and History** | Mother | Father |
| Mental illness including anxiety or depression |  |  |
| Serious medical condition or disability |  |  |
| Learning diﬃculty or low educational achievement |  |  |
| Alcohol and/or substance misuse |  |  |
| Current domestic violence or abuse |  |  |
| Historical violence in the family |  |  |
| Significant bereavement |  |  |
| Poor or conflictual partner relationship between parents |  |  |
| Social isolation / lack of support structures |  |  |
| Chaotic lifestyle |  |  |
| Financial diﬃculties |  |  |

|  |  |  |
| --- | --- | --- |
| **Interaction and relationship Concerns** | Mother | Father |
| Insensitive or inconsistent caregiving |  |  |
| Poor eye contact / avoidant infant behaviours |  |  |
| Lack of developmentally appropriate interactions |  |  |
| Caregiver does not enjoy the baby |  |  |
| Negative feelings towards the baby |  |  |
| Neglect or maltreatment (if yes please give details in referral) |  |  |

**Section B**

|  |  |
| --- | --- |
| Current concerns: |  |
|  |  |
| Summary of reasons for this referral |  |
|  |  |
| Current or previous interventions |  |
|  |  |
| How would you like your relationship with your baby to be different? |  |

# Referrer Details

Name: Signature:

Role: Telephone:

Date: Email:

# Parental consent:

I confirm that I consent to being referred to this support service

Date

* Parental Consent must be obtained before submitting a referral.
* The referrer may be contacted to discuss the information in this referral in more detail.
* We collect the information in this referral form in order to assess what services we may be able to offer you.
* When we receive a referral form, it is processed and recorded on our online database where it is kept secure and confidential – your information is anonymized, password protected.