CAFS (Children & Families Staffordshire)
REFERRAL FORM

CAFS
Supporting our families

WE ARE UNABLE TO PROCESS YOUR REFERRAL UNTIL WE RECEIVE THIS FORM

Please note that all referrals must be made with the consent of the family.
Information on this form will be shared with the family.

Family No. (*office use only*)

Parent 1 Name:		Parent 1 Gender:	Main Carer? Yes ☐ No ☐
Date of Birth:	Parent 1 Ethnicity:	Parent 1 Disability: Yes ☐ No ☐	
Parent 2 Name *(if living in household):*		Parent 2 Gender:	Main Carer? Yes ☐ No ☐
Parent 2 Date of Birth:	Parent 2 Ethnicity:	Parent 2 Disability: Yes ☐ No ☐	
Full address including postcode:			
Contact telephone no.:		Is an interpreter required for this family? Yes ☐ No ☐	

Referred by:

Name:	Address including postcode:
Role:	
Agency:	Tel No:
Email address:	
Other agencies involved:	

If you feel the family would benefit from Family Links Nurturing Parenting Programme please tick box below.

☐ **Family Links Nurturing Parenting Programme**

Supported by BBC Children in Need · People's Postcode Lottery · People's Postcode Trust · Community Fund · Time to Talk · Family Links

Details of all children under 18:

Child's Name Eldest First	Gender		Date of Birth	Considered disabled by main carer?	Asian or Asian British				Black or Black British			Chinese		Mixed				White			Any Other Back-ground	Subject to assessment of needs e.g. Early Help *(See extra info reqrd below)*	Child in Need	Child Care / Protection Plan
	Male	Female			Indian	Pakistani	Bangladeshi	Other Asian *(specify)*	Caribbean	African	Other Black *(specify)*	Chinese	Chinese Other *(specify)*	White & Black Caribbean	White & Black African	White & Asian	Other Mixed *(specify)*	British	Irish	Other White *(specify)*	Any Other Background *(specify)*			
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For families with more than four children, please attach additional sheet

Next Early Help Meeting. Please supply date, time, venue, name of lead professional and telephone no.

Please tick all that apply:

Lone parent ☐	Substance abuse ☐	Domestic abuse ☐	Emotional wellbeing / mental health issues ☐
Learning difficulties ☐	Financial difficulties ☐	Communication ☐	Teenage pregnancy 21 years or younger ☐

Background information: *(please attach an additional sheet if more space required)*

Referrer's Signature:	Date:
Parent's Signature: *(optional)*	Date:

Checklist for Referrer:

☐ 1. Family have consented to referral

☐ 2. If an Early Help, Child in Need or Child Protection Plan is in place – Signs of Safety Action Plan is attached

☐ 3. Risk assessment is attached

We try to respond to all referrers within 8 weeks after receiving the referral to report progress.
If you have any issues or concerns about the referral process or the support for the family, please contact us.

Return to: CAFS, Bridge Centre, Birches Head Road, SOT, ST2 8DD. Tel: 01782 863762; Email: info@cafstaffordshire.org.uk