

# Referral Form for Family Wellbeing Service Parenting, Portage and 0-5 SEND Family/Parenting Support



September 2021

For families who are residents of the London Borough of Merton

For further information on services available and a current delivery timetable visit [merton.gov.uk/childrenscentres](http://merton.gov.uk/childrenscentres)

**All fields with a red asterisk \* must be completed; if they are not completed your form will be returned.**

Please return your completed form to: [fsd@merton.gov.uk](mailto:fsd@merton.gov.uk) following your organisation's secure exchange protocol, along with copies of any relevant supporting information, such as EH or C&F Assessment, paediatric report etc

1. REFERRER INFORMATION – * BLOCK CAPITALS ONLY PLEASE *	
Family eStart / Mosaic ID	Referrer's agency/service*
Referrer's name*	Referrer's telephone*
Referrer's email* <i>This must be provided for the referrer to receive feedback</i>	

2. FAMILY INFORMATION – * BLOCK CAPITALS ONLY PLEASE *	
PRIMARY CARER 1 (e.g. mother/father)	PRIMARY CARER 2 (e.g. mother/father)
Name*	Name*
Telephone*	Telephone*
Date of birth	Date of birth
Address and postcode*	Address and Postcode*
Contact email* <i>All booking information will be sent via email.</i>	Contact email* <i>All booking information will be sent via email.</i>
Relationship to child*	Relationship to child*
Lone parent?	Lone parent?
Disabilities / Health needs	Disabilities / Health needs
Special Educational Needs	Special Educational Needs
Ethnicity	Ethnicity
First Language	First Language
Is support required with speaking, writing or reading English?*	Is support required with speaking, writing or reading English?*

CHILDREN		Gender	Disability / Health needs	Special Educational Needs
Child 1*	Name:	Male / Female	Yes / No	Yes / No
	Date of Birth:			
	Ethnicity:			
	Name of Preschool/Nursery/School/Childminder			
Child 2*	Name:	Male/Female	Yes / No	Yes / No
	Date of Birth:			
	Ethnicity:			
	Name of Preschool/Nursery/School/Childminder			
Child 3*	Name:	Male / Female	Yes / No	Yes / No
	Date of Birth:			
	Ethnicity:			
	Name of Preschool/Nursery/School/Childminder			
Child 4*	Name:	Male / Female	Yes/No	Yes / No
	Date of Birth:			
	Ethnicity:			
	Name of Preschool/Nursery/School/Childminder			

### 3. REFERRAL INFORMATION – This section must be fully completed with as much detail as possible \*

Please outline what is currently working well for the family (continue on additional sheet if necessary)

Please outline what you or the family are worried about

### 4. SERVICE REQUEST

#### A) Family Wellbeing Service Parenting Programmes

Name of child requiring service				
Parenting programme	Age range	Eligibility Criteria	Key focus of programme	Select one
<b>Triple P</b>	3 to 10yrs	Families with needs at L3/4 of Effective Support Model, evidenced in Targeted Early Help Assessment or C&F Assessment – to be submitted with referral	Understanding developmental needs and supporting emotional and behavioural development	<input type="checkbox"/>
<b>Triple P: Teens</b>	11 to 16yrs	Child aged 13 to 18	Understanding developmental needs and supporting emotional and behavioural development: Self-regulation. Planning around risky behaviours or activities	<input type="checkbox"/>
<b>Triple P: Stepping Stones for children with disabilities</b>	5 to 12yrs	Families with needs at L3/4 of Effective Support Model, evidenced in Targeted Early Help Assessment or C&F Assessment who have a child with disability	Understand developmental needs and support emotional and behavioural development of children and young people with SEND	<input type="checkbox"/>
<b>Freedom Programme – for Women</b>	N/A	Families with needs at L3/4 of Effective Support Model, evidenced in Targeted Early Help Assessment or C&F Assessment who are or have experienced domestic abuse	Support to understand the impact of abusive relationships and consider how to build and enjoy healthy relationships	<input type="checkbox"/>
<b>Freedom Programme – for Children</b>	Primary Sch Age			<input type="checkbox"/>
<b>Freedom Programme – for male perpetrators</b>	N/A			<input type="checkbox"/>
<b>Incredible Years: ASD / Language Delay</b>	2yrs to end of Reception year	Child on the autism spectrum or with language delay	Challenging behaviour, emotional regulation, language and social skills, school readiness	<input type="checkbox"/>

**B) Portage & 0-5 SEND Family/Parenting Support**

Education, parenting and family support programmes for children with complex needs, SEND, developmental delay

**Eligibility Criteria****Child with complex needs, SEND, developmental delay****Supporting Evidence**Paediatric/OT/S&LT report / Assessment Specialist Report / Assessment (health visitor ASQ) **Name of child requiring service****5. PARENT / CARER VIEWS \*****Use this space for the family to record their views about how the service or services requested will support them and what they hope to gain from this****6. CONSENT \*****Data Protection Agreement**

I understand that receiving Early Help and Targeted Early Help support is voluntary and the information I give on this form will be shared with the Early Years, Family Wellbeing and Early Help service to identify what support may be needed and to help plan support for me and my family. This may involve the sharing of my information with one or more of the following professionals / agencies where considered necessary so that they can help to plan and provide support for me and my family:-

- Education Providers e.g. nurseries, schools and colleges;
- Social Care services;
- Health- GPs or Health Visitors;
- Counselling Services;
- Housing Providers;
- Local Job Centres;
- Victim Support;
- Voluntary and Community Sector Bodies.

I understand that my information will be stored safely as per the General Data Protection Regulation. If you would like more information about how your information is processed please ask your Practitioner or see our website at [Privacy notice \(merton.gov.uk\)](http://merton.gov.uk/privacy-notice)

**WE MAY CONTACT YOU BY PHONE TO DISCUSS THIS REFERRAL AND / OR TO BOOK YOU ONTO A PROGRAMME  
PLEASE NOTE THAT YOUR TELEPHONE WILL SHOW THIS CALL AS COMING FROM AN UNKNOWN NUMBER**

**Parent / carer signature****Verbal consent received - State Yes or No****Date:**Please check that you have completed the form fully before sending it securely to [fsd@merton.gov.uk](mailto:fsd@merton.gov.uk)

Please note that some services will require further assessment to determine suitability.

The referrer and parent / carer will always be advised of the outcome and will receive confirmation of the service(s) offered.