**Referral to Families Together Programme (FTP) – Sandwell**

**Before completing this referral please ensure that you have referred to the Guidance Notes PDF Document**

**Please ensure that all fields of this referral form are completed - if not, the referral shall be declined**

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| **REFERRING OFFICER DETAILS** |
| **Full Name** |  |
| **Service / Agency** |  |
| **Contact Details** ***(Telephone Number & Work Mobile, E-Mail Address & Postal Address)*** |  |
| **CLIENT DETAILS** |
| **Full Name** |  |
| **E-Mail Address *(We will use this to send their acceptance letter & end of Programme report)*** |  |
| **Postal Address** |  |
| **Telephone Number*(s)*** |  |
| **Ethnicity** |  |
| **First Language** |  |
| **Age / DOB** |  |
| **Any known Disabilities** |  |
| **Any known Risk Factors e.g is this person a perpetrator of DVA** |  |
| **Any Alcohol / Substance Misuse issues** |  |
| **Any Current / Previous Criminal convictions** |  |
| **PARTNERS DETAILS** |
| **Full Name** |  |
| **E-Mail Address *(we will use this to send their acceptance letter & end of Programme report)*** |  |
| **Postal Address** |  |
| **Telephone Number*(s)*** |  |
| **Ethnicity** |  |
| **First Language** |  |
| **Age / DOB** |  |

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| **Any known Disabilities** |  |
| **Any known Risk Factors e.g is this person a perpetrator of DVA** |  |
| **Any Alcohol / Substance Misuse issues** |  |
| **Any Current / Previous Criminal convictions** |  |
| **CHILD/REN’S DETAILS** |
| **Name*(s)*** |  |
| **Age*(s)* / DOB*(s)*** |  |
| **School / Nursery Details** |  |
| **Relationship *(e.g. step-children)*** |  |
| **REASON FOR MAKING REFERRAL? Please detail why you are making this referral, e.g. any incidents, relationship break-down, reason for social services intervention with family etc.** |
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| **PREFERRED TIMES OF ENGAGEMENT *(e.g. any working commitments of parents)*** |
| **Please place an ‘X’ next to the clients preference from the options below:*** Evening Group
* Day-time Group
* 3 x telephone sessions, including DVA awareness and signposting
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**This referral will not be accepted unless both parents have wet signed/verbally agreed to the referral.**

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| **CONSENT OF PARENT*(S)* to engage with Family Action and to allow Family Action staff to make contact with them soon after referral to our service.** |
| **Client’s Full Name** |  |
| **Signature** |  |
| **Partner’s Full Name** |  |
| **Signature** |  |
| **Date** |  |

**\*\*\* End of Referral Form \*\*\***