**CONFIDENTIAL**



**PSS Parent and Baby Service**

#### Please provide as much information as possible. If this form hasn’t been signed by the parent or carer, we’ll be unable to accept this referral.

For referrer/parent/carer to fill in:

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/carer one** | | **Parent/carer two (where applicable)** | |
| First name |  | First name |  |
| Surname |  | Surname |  |
| Gender |  | Gender |  |
| Date of birth |  | Date of birth |  |
| Ethnicity |  | Ethnicity |  |
| Email |  | Email |  |
| Phone number |  | Phone number |  |
| Address |  | Address |  |
| Post code |  | Post code |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Bump/Baby’s details** | | | | | |
| First name |  | | Surname | |  |
| Date of birth or due date |  | | Gender and ethnicity | |  |
| Does your child have any medical conditions or disabilities? If yes, please tell us. | | | | | |
| Is the family open to Social Services? Please tick the appropriate box or tick not applicable - N/A.  EHAT CIN Child Protection LAC N/A | | | | | |
| **Additional needs -** Thinking about the family as a whole, please can you let us know about any other additional needs they may have by ticking all that apply. | | | | | |
| **Postnatal depression**  **Financial need**  **Involvement with CJS**  **Special educational need** | | **Domestic abuse**  **Housing need**  **Low confidence/self-esteem**  **Alcohol/drugs** | | **Asylum seeker/refugee**  **Bereavement/loss**  **Care leaver**  **11**  **Isolation** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other family members** | | | |
| For any additional family members, please tell us their name, address, contact information and how they’re related to the child, for example if they are a sibling or a grandparent. | Gender | DOB/DD | Ethnicity |
|  |  |  |  |
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| --- |
| Are there any accessibility or risk issues regarding home visiting and/or lone working? |
| none |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer details** | | | |
| Name |  | Job title |  |
| Organisation |  | Phone number |  |
| Address |  | | |
| Email |  | | |

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| **Reason for referral** |
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| **Contact with any other agencies** |
| Please tell us their name, role, base, and telephone numbers, thank you.  *(Eg, Adult mental health, CAMHS, Children’s Centre, child protection, court welfare, domestic violence, drugs project, fostering/adoption, looked after children, midwife, nursery, obstetrics, probation services, Social Services, substance misuse agencies, teenage agencies, voluntary agencies.)* |

|  |  |  |  |
| --- | --- | --- | --- |
| **GP and health visitor (HV) details – required** | | | |
| GP’s name |  | HV’s name |  |
| GP practice and address |  | HV address |  |
| GP phone number |  | HV phone number |  |

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**DECLARATION** *(to be signed by parent or carer please)*

#### I agree to this referral to the PSS Parent and Baby Service and the following information:

#### A file will be opened in my child’s name (and kept securely under the Data Protection Act 1988). My GP will be sent a brief summary of plans and some information about the service. Information will only be shared with other professionals when necessary, and after it has been discussed with me. The Parent-Baby Service team will talk to me about what is going to happen and suggest things that will be useful for me. They will also talk through options including the use of video, family meetings and groups.

Parent/carer’s name:

Date:

Please return this completed form to:

**PSS, Eleanor Rathbone House, Connect Business Village, 24 Derby Road, Liverpool, L5 9PR.**

Email: [**parentandbaby@pss.org.uk**](mailto:parentandbaby@pss.org.uk)

Telephone: **0151 702 5535** Fax: **0151 702 5566**

Signature: