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| *For Barnardos Office use only* |
|      Referral received by |      Date referral received |      Referral allocated to |      Date referral allocated |

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| **CHILD AND FAMILY INFORMATION** |
| The Barnardos LEAP service provides support and interventions to vulnerable children and families. The purpose of the service is to keep vulnerable children and their families safe and reduce the risk of maltreatment particularly where there are complex and multiple needs. | **COMPLETE ONE FORM PER FAMILY** |
| **Name of child/ren** Family Name First Name | **DOB** DD/MM/YY | **Gender** | **Ethnicity** | **Country of birth** |
|  |  |       |       |       |       |
|  |  |       |       |       |       |
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| **Contact details where child/ren live** |
| **Carer one**Family Name   | First Name  | DOBDD/MM/YY       | Ethnicity       |
| Unit no./ Street no./ Street name       | Relationship to baby       |
| Town/ City       | Postcode       | Language spoken at home:       | Interpreter required? YES [ ]   |
| Home phone no.       | Preferred method of contact  | Indicate who is aware of this referralCarer one [ ] Carer two [ ]  |
| Mobile phone no.       | Work phone no.       | Email address       |
| **Carer two**Family Name   | First Name  | DOBDD/MM/YY       | Ethnicity       |
| Mobile phone no.       | Work phone no.       | Email address       | Relationship to baby        |

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| **Details of other people living at the child’s address** |
| Name | Relationship to child*e.g. Maternal G/parent* | Name | Relationship to child |
|       |       |       |       |
|       |       |       |       |
| **Details of other significant people in child’s life NOT living at child’s address** |
| Name | Relationship to child*e.g. Maternal G/parent* | Name | Relationship to child |
|       |       |       |       |
|       |       |       |       |
| **REFERRER/ REFERRAL AGENCY INFORMATION** |

**REASON FOR REFERRAL**

Please TICK which of the following vulnerability categories are present and detail the supporting evidence.

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| **VULNERABILITY CATEGORY** | Evidence that this vulnerability is present | **✓** | Provide further details, or other evidence, relating to this vulnerability category |
| **Family Violence (FV)** | Current Protection Order (PO) | [ ]  |        |
| Police callouts for FV in last 12 months | [ ]  |
| Injury to protected person and/or child from FV incident | [ ]  |
| FV incident or breach of PO in last 12 months | [ ]  |
| **Parental mental health issues** | Diagnosis of adult mental health condition | [ ]  |        |
| Acute symptoms of adult mental health condition | [ ]  |
| Compulsory Assessment and Treatment Order  | [ ]  |
| **Alcohol or drug misuse** | Criminal conviction for drug or alcohol | [ ]  |        |
| Acute symptoms of drug or alcohol abuse | [ ]  |
| Orders for detention and treatment under the Alcoholism and Drug Addiction Act | [ ]  |
| **Neglect or emotional abuse** | Substantiated finding of child abuse | [ ]  |        |
| **Child has significant health issues or disability** | Diagnosis of significant child health condition or disability | [ ]  |        |
| Multiple health or disability issues | [ ]  |
| **Risk of or actual statutory involvement**  | Multiple notifications in the last 12 months | [ ]  |        |
| FGC convened in the last 12 months | [ ]  |
| Is or has been in state care | [ ]  |

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| **IMPACT ON THE CHILD/REN** |
| **Please explain what you have noticed about the child/ren that suggests to you they are vulnerable**      |

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| **OTHER AGENCIES KNOWN TO BE INVOLVED WITH THE CHILD/REN OR FAMILY**  |
|       |

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| **SOCIOECONOMIC ‘AT HIGHER RISK’ FACTORS** |
| Parenting alone | YES [ ]  NO [ ]  UNKNOWN [ ]   |
| Young parent (< 20 years) | YES [ ]  NO [ ]  UNKNOWN [ ]   |
| Young parent between 20 and 25 years | YES [ ]  NO [ ]  UNKNOWN [ ]   |
| Parent has been in statutory care | YES [ ]  NO [ ]  UNKNOWN [ ]   |
| Parent with a criminal conviction | YES [ ]  NO [ ]  UNKNOWN [ ]   |
| Family on income tested benefit | YES [ ]  NO [ ]  UNKNOWN [ ]   |
| Temporary housing | YES [ ]  NO [ ]  UNKNOWN [ ]   |

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| **INTERVENTION SOUGHT** |
| (if known) **Indicate which LEAP service package size you are seeking for this family** **LEAP Targeted (10)** [ ]  **LEAP Intensive (40)** [ ] **Please tell us what you are asking Barnardos LEAP service to deliver for the referred family**       |

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| **LIST ANY DOCUMENTS ATTACHED** |
| **Statutory referral – Tuituia attached** | YES [ ]  NO [ ]   |
|       |
|       |
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| **REFERRED BY:** |
| Persons name |      Job Title |
|      Agency name |
| **Contact details of referrer:** |
|      Mobile phone no. |      Work phone no. |      FAX no. |      Email address |
|      Postal address |      Postcode |
| **Date of referral:**       |

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| BARNARDOS USE ONLY | OUTCOME: L 1. [ ]  L 2. [ ]  | DNC. [ ] Does not meet criteria | Intake Assessor:       |