**WHO’S IN CHARGE REFERRAL FORM**

PLEASE READ THE BELOW BEFORE COMPLETING THE REFERRAL FORM

**Who’s in Charge?** is a 9-week child to parent violence (CPV) programme aimed at parents whose children are aged between 8 – 18 years old and are being abusive or violent toward them or who appear out of parental control.  The structure of the programme consists of 8 two and a half hour sessions with a two-month follow up which the parent(s) must be able to commit to. Parental consent must also be gained before completing the referral.

Please tick here if the family being referred meet these criteria

Has parental consent been received

|  |  |
| --- | --- |
| **Information about the person making the referral** | |
|  | |
| Date of referral: |  |
| Name of Programme: |  |
| **Please ensure all below sections are completed** | |
| Referrer’s name (if applicable) |  |
| Organisation name (if applicable) |  |
| Role/ job title (if applicable) |  |
| Contact number |  |
| Contact email |  |

**Information about the parent(s) wishing to complete the programme (if an additional parent is accompanying, please specify this in parent 2 section).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parent 1** |  | | **Parent 2 (if applicable, state relationship to child/ren)** |  | |
| First name |  | | First Name |  | |
| Last name |  | | Last Name |  | |
| Other names |  | | Other Names |  | |
| What do they like to be called? |  | | What do they like to be called |  | |
| DOB |  | | DOB |  | |
| Parental responsibility of Child? ‘x’ if yes. |  | | Parental responsibility of child? ‘x’ if yes. |  | |
| **Current address** |  | | **Current address (if different to Parent 1)** |  | |
| **Contact Info** | *Details* | *Safe to contact? ‘X’ if yes* | **Contact info** | *Details* | *Safe to contact?*  *‘X’ if yes* |
| Contact Number |  |  | Contact Number |  |  |
| Is it safe to leave message Y/N |  |  | Is it safe to leave a message Y/N |  |  |
| Email- use box below if needed |  |  | Email- use box below if needed |  |  |
|  | | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please provide a safe additional contact for emergency purposes ONLY** | | | |
| Name & relationship to client |  | Name and relationship to client |  |
| Contact Number |  | Contact number |  |

**Client equalities monitoring**

**Client 1:**

|  |  |  |
| --- | --- | --- |
| Client Gender | Female | Male |
| Do they have any kind of disability?  (please tick any that apply) | Physical  Learning  Mental Health  Deaf/ hearing impaired  Blind/ visually impaired  Something else:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| How would they describe their ethnicity? | | |
| White British  White Irish  White Gypsy or Irish Traveller  Any other White background  Asian British  Asian Indian  Asian Pakistani  Asian Bangladeshi  Any other Asian background  Chinese  Arab | White and Black Caribbean  White and Black African  White and Asian  Any other mixed/ multiple background  Black British  Black African  Black Caribbean  Any other Black background  Other (please specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| Do they have a faith/ religion? | | |
| No religion  Bahai  Buddhist  Christian  Hindu  Jewish  Jain | Muslim  Shinto  Sikh  Zoroastrian  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| What is client’s nationality? |  | |

**Client 2 (if applicable):**

|  |  |  |
| --- | --- | --- |
| Client Gender | Female | Male |
| Do they have any kind of disability?  (please tick any that apply) | Physical  Learning  Mental Health  Deaf/ hearing impaired  Blind/ visually impaired  Something else:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| How would they describe their ethnicity? | | |
| White British  White Irish  White Gypsy or Irish Traveller  Any other White background  Asian British  Asian Indian  Asian Pakistani  Asian Bangladeshi  Any other Asian background  Chinese  Arab | White and Black Caribbean  White and Black African  White and Asian  Any other mixed/ multiple background  Black British  Black African  Black Caribbean  Any other Black background  Other (please specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| Do they have a faith/ religion? | | |
| No religion  Bahai  Buddhist  Christian  Hindu  Jewish  Jain | Muslim  Shinto  Sikh  Zoroastrian  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| What is client’s nationality? |  | |

**Household Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Details of all **adults** in the household where the child/YP is living | | | | | |
| **Name** | **DOB** | **Gender** | **Ethnicity/Language** | **Disability (if yes, please specify)** | **Relationship to child** |
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| --- | --- | --- | --- | --- | --- |
| Details of all **children** in the household where the child/YP is living (start with most challenging child first) | | | | | |
| **Name** | **DOB** | **Gender** | **Ethnicity/Language** | **Disability (if yes, please specify)** | **School/ nursery** |
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**Additional Needs and involvement**

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| --- | --- | --- |
| Is there any social care involvement in this case? | Yes | No |
| *(Please provide details including any plans)* |  | |
| Name of allocated worker and contact details  *(if relevant)* |  | |
| Does client have additional needs? | Yes | No |
| If yes please provide an overview of support needs |  | |

**Reason for referral**

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| --- |
| **Please give details of issues within the family environment, including any significant events that have led to making the referral.** |
|  |
| **How has this impacted the family?** |
|  |

**To submit this referral please email it to advice@ndas-org.co.uk**

**If you have any queries, please email** **advice@ndas-org.co.uk** or call **0300 0120 154**.