**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/carer violence (CPV) programme aimed at parents/carers 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.

* Has parental/carer consent for this referral been given? YES / NO
* Is the Child/young person between 8 – 18 yrs old? YES / NO

***PLEASE NOTE WE DO NOT ACCEPT MORE THAN ONE REFERRAL FOR GROUPWORK, PER PERSON AT ANY ONE TIME.***

|  |  |
| --- | --- |
| **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).*

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| --- | --- | --- | --- | --- | --- |
| **Parent/Carer 1** | | | **Parent/Carer 2** *(if applicable, state relationship to child/ren)* | | |
| **First name** |  | | **First Name** |  | |
| **Last name** |  | | **Last Name** |  | |
| **Pronouns** |  | | **Pronouns** |  | |
| **Preferred name** |  | | **Preferred name** |  | |
| **Date of Birth** |  | | **Date of Birth** |  | |
| **Do they have Parental responsibility/Guardianship for the Child?** | YES / NO | | **Do they have Parental responsibility/Guardianship for the Child?** | YES / NO | |
| **Current address** |  | | **Current address (if different to Parent 1)** |  | |
| **Parent 1 contact information:** | | | **Parent 2 contact information:** | | |
| **Phone Number** |  | | **Phone Number** |  | |
| **Is it safe to…** | Call:  Text:  Voicemail:  Email: | YES / NO  YES / NO  YES / NO  YES / NO | **Is it safe to …** | Call:  Text:  Voicemail:  Email: | YES / NO  YES / NO  YES / NO  YES / NO |
| **Email address** |  | | **Email** |  | |
| **Has this parent/carer received support around Domestic Abuse?** | Yes | No | **Has this parent/carer received support around Domestic Abuse?** | Yes | No |

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

**Client (Parent/Carer) equalities monitoring**

**Parent/Carer 1:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parent/Carer 1’s Gender Identity:** | Female | Male | Non-Binary | Other |
| **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?** |  | | | |

**Parent/Carer 2 (if applicable):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parent/Carer 2’s Gender Identity:** | Female | Male | Non-Binary | Other |
| 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**

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| --- | --- | --- | --- | --- | --- |
| Details of all **adults** in the household where the child/young person 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)* |  | |
| **Do either the parent/carer or child have additional learning 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 on 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**.