**GROWING TOGETHER REFERRAL FORM**

**PLEASE NOTE WE ARE NOT AN EMERGENCY SERVICE. IF THERE IS SIGNIFICANT OR IMMEDIATE RISK PLEASE REFER TO EMERGENCY OR CRISIS SERVICES. FOR ANY CONCERN ABOUT A CHILD PLEASE REFER TO CHILDRENS SOCIAL CARE.   
If you would like to discuss a potential referral please call 020 3316 1824 or email** [**growingtogether@nhs.net**](mailto:growingtogether@nhs.net) **(for use by referrers only)**

|  |
| --- |
| **DATE:** |

|  |  |
| --- | --- |
| REFERRERS NAME: | ADDRESS: |
| JOB TITLE AND ORGANISATION: | PHONE NUMBER: |
| EMAIL: |

**PARENT/CARER 1:**

|  |  |  |
| --- | --- | --- |
| NAME: | DOB: | NHS no: |
| ADDRESS: | CONTACT NUMBER:  Email: | |
| Is an interpreter needed? YES / NO  Specify what language: | ETHNICITY:  FIRST LANGUAGE: | |
| Are they open to any other mental health services? YES / NO ***We cannot accept the referral if the parent is currently using another mental health service*** | | |
| Are you referring this parent to our service? Yes/No Has the parent consented to the referral? Yes/No  ***Please only refer parent(s) with mental health difficulties. We cannot accept the referral without the parent’s consent.*** | | |

**PARENT/CARER 2 (including step-parents):**

|  |  |  |
| --- | --- | --- |
| NAME: | DOB: | NHS no: |
| ADDRESS: | CONTACT NUMBER: | |
| Is an interpreter needed? YES / NO  Specify what language: | ETHNICITY:  FIRST LANGUAGE: | |
| Are they open to any other mental health services? YES / NO ***We cannot accept the referral if the parent is currently using another mental health service*** | | |
| Are you referring this parent to our service? Yes/No Has the parent consented to the referral? Yes/No  ***Please only refer parent(s) with mental health difficulties. We cannot accept the referral without the parent’s consent.*** | | |

**CHILD/CHILDREN AGED 1-5**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **DOB** | **Who does the child live with?** | **Child’s ethnicity** | **Tick if referring (child must be aged 1-5 years and have a presenting difficulty)** |
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|  |  |  |  | ☐ |
|  |  |  |  | ☐ |
|  |  |  |  | ☐ |

**ANY OTHER MEMBER OF THE HOUSEHOLD**

|  |  |  |
| --- | --- | --- |
| **NAME** | **DOB** | **RELATIONSHIP TO CHILD/PARENT** |
|  |  |  |

**Please continue on next page…**

**PROFESSIONALS**

|  |  |
| --- | --- |
| **GP:** | GP’S ADDRESS: |
| PHONE: | EMAIL: |

|  |  |
| --- | --- |
| **HEALTH VISITING TEAM:** | ADDRESS: |
| PHONE: | EMAIL: |

|  |  |
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| **SOCIAL WORKER:** | ADDRESS: |
| PHONE: | EMAIL: |

|  |  |
| --- | --- |
| **ANY OTHER SERVICE INVOLVED:** | ADDRESS: |
| PHONE: | EMAIL: |

REASONS FOR REFERRAL *(Note:* ***both*** *parent(s) and child(ren) need to be presenting with difficulties for a referral to be accepted)*

* Please give a brief description of the parent’s mental health/psychological difficulties   
  *(note: these would need to be mild-moderate for a referral to be accepted)*

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* Please describe the difficulties the child (aged 1-5) is presenting with, e.g. seems withdrawn, sad or anxious; shows aggressive, hyperactive or repetitive behaviours; has difficulties with separation, sleep, toileting, feeding or in their relationship with their parent/s

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* Are there any risk issues, e.g. risk of suicide/self-harm/physical aggression, vulnerability, self-neglect and/or concerns about the child/ren’s wellbeing and safety?
* How are the risks currently being managed?

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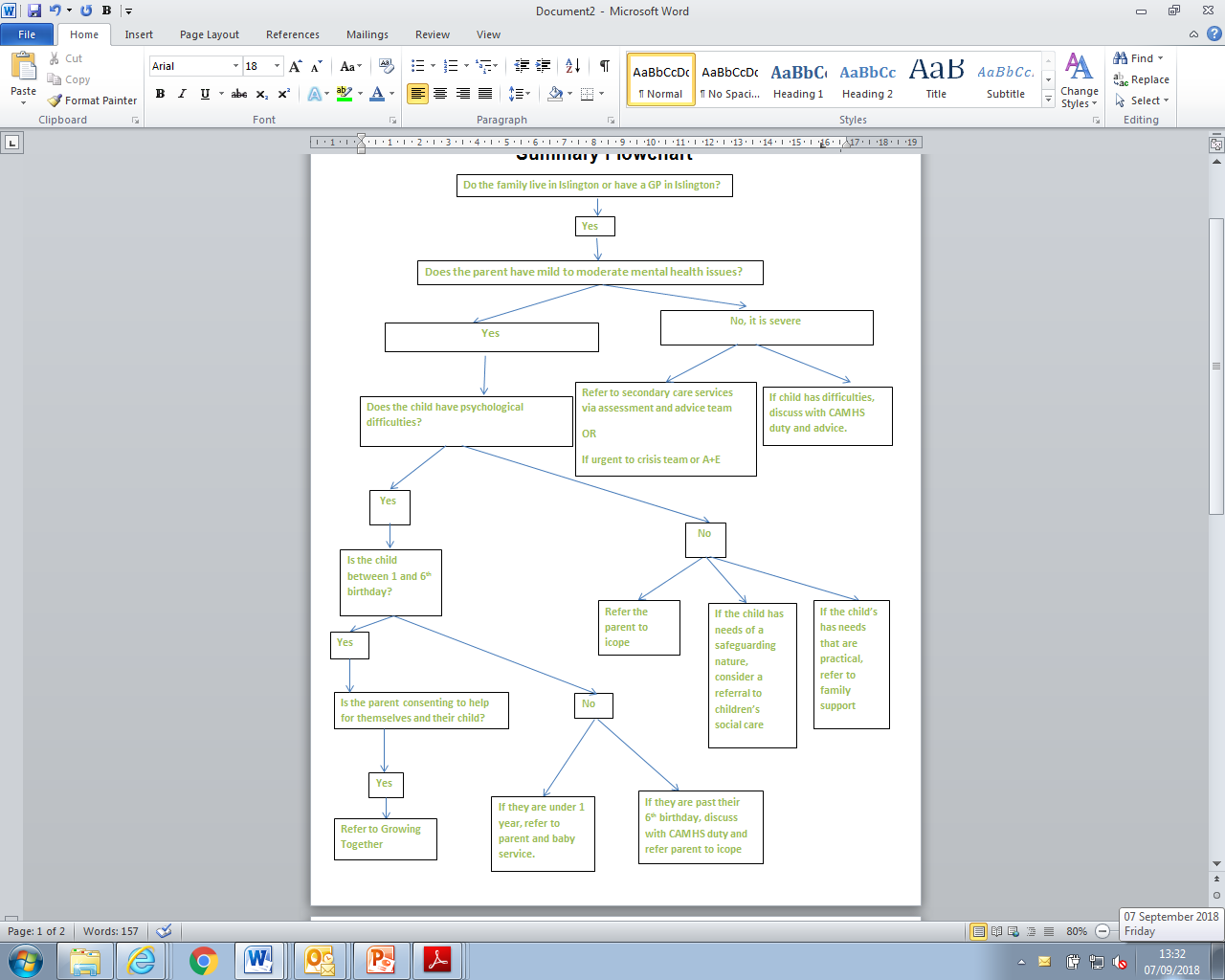
* How did you hear about our service? Please circle the answer that applies most

Leaflet/Poster Stall Meeting Training Website Community event Email

Stay and Play Workshops ESOL class Story & Rhyme **Professional**  Other (please specify)

**Growing Together referral criteria:**Summary Flowchart

**PLEASE EMAIL TO GROWING TOGETHER: [growingtogether@nhs.net](mailto:growingtogether@nhs.net)**



**We have the following interventions available:   
*(please note that the actual option offered will be based upon our clinical assessment)***

|  |  |
| --- | --- |
| **Workshops (2 hours, daytime – no referral needed)**  -Stress Less Parenting  -Calmer Nights Sleep Workshop  **MindSkills group (2 hours, daytime)**  A 6-week course for parents to learn CBT skills to manage depression or anxiety  **Mellow Parenting Group (5 hours, daytime)** A 15-week parenting group for mothers with children aged  1-5 years old | **Adult psychological therapies**  **Parent-infant/child psychotherapy**  **Family/couple therapy**  **Child behaviour management and parenting advice**  **Personalised Individualised Parent Training (PIPT)** |