**Client Referral Form - Enhancing Families Programme**

All pregnant women who meet 1 or more of the following criteria will be offered an Enhancing Families Nurse if it is their first pregnancy or other children have been removed from their care.

Please mark any of the below that apply, for eligibility:

|  |  |
| --- | --- |
| 18 years and under |  |
| Identified as having SEND or social communication challenges |  |
| Current drugs and or alcohol misuse |  |
| Current concerns of domestic abuse in relationship |  |
| Looked after child or care leaver |  |
| Refugees |  |
| Current mental health issues (if any of above criteria are also met) |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client forename(s) | | Client surname | DOB | NHS Number |
|  | |  | XX/XX/XX | XXX XXX XXXX |
| Partner / Baby’s father forename(s) | | Partner’s surname | DOB |  |
|  | |  | XX/XX/XX |  |
| Client’s ethnicity |  | Partner’s ethnicity |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Client’s ethnicity |  | Partner’s ethnicity |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address | | | |  | | | | | | | | | | | | |
| Phone number(s) | | | |  | | | | | | | | | | | | |
| Email address | | | |  | | | | | | | | | | | | |
|  | | | | LMP | | XX/XX/XX | | EDD | XX/XX/XX | | | Gestation | | | XX weeks XX days | |
| EHAT |  | | | FAM | |  | | CP |  | | | | LAC | |  | |
| Client consent to text | | | | | Yes | | No | Consent to leave a message | | | | | | Yes | | No |
| Midwife | |  | | | | | | | | GP |  | | | | | |
| Further relevant information: | | | | | | | | | | | | | | | | |
| Referral by | | |  | | | | | | | | | | | | | |
| Contact number | | |  | | | | | | | | | | | | | |
| Position held | | |  | | | | | | | | | | | | | |

**Please email completed form to:** [**enhancingfamiliesteam@nhs.net**](mailto:enhancingfamiliesteam@nhs.net)