**Enhancing Families Programme - Cheshire East**

**Referral Form**

**Eligibility**

Please mark any of the below that apply for eligibility onto the programme:

|  |  |
| --- | --- |
|  | Yes/No/Unknown/N/A |
| Under 32 weeks gestation |  |
| Been through the care system  |  |
| Had an older child removed and placed in care. |  |
| Learning or physical disabilities  |  |
| Previous or current mental health concerns |  |
| Previous or current drugs and or alcohol misuse |  |
| Previous or current concerns of domestic abuse in relationship  |  |
|  |  |
| Experienced when they were growing up: |  |
| * Neglect, physical, emotional or sexual abuse.
 |  |
| * Domestic abuse
 |  |
| * Abandoned by a parent through separation or divorce
 |  |
| * Close family member having a mental illness
 |  |
| * Close family member been in prison
 |  |
| * Close family member misusing drugs and/or alcohol
 |  |
| **Please provide any relevant comments in relation to your answers above:** |

**Please note the Enhancing Families Programme is not aimed at families already on a child protection plan. Please contact the service lead to discuss any individual cases - 0300 123 4068 /** **wcnt.cheshireeastfnp@nhs.net**

|  |
| --- |
| **Client details** |
| First name: | Last name: | DOB | NHS number |
|  |  |  |  |
| Ethnicity  |

|  |  |
| --- | --- |
| Address including postcode |  |
| Contact telephone number |  |
| Email  |  |
| **Partner details (if known)** |
| First name: | Last name:  | Date of Birth: | Ethnicity:  |
| **History of social care involvement:**  |
| **Is there Child Protection/Child in Need/Early Help plan currently in place?** |
| **Details of social worker/family service worker:**Name:Telephone number:Email address: |
| **Details of previous pregnancies/births:** |
| **Client medical details current pregnancy:** |
| Last menstrual period: | Estimated due date: | Gestation weeks: |
| Client consent to text  | Yes  | No  | Consent to leave a message  | Yes  | No |
| **Health and care professional details** |
| Name of midwife  |  | Name of GP |  |
| Supporting multi-disciplinary information / additional information  |
| **Referrer details** |
| Referral by (name and job title) |  |
| Contact telephone number  |  |
| Please email completed form to: | wcnt.cheshireeastfnp@nhs.net |