**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**](mailto: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](mailto:wcnt.cheshireeastfnp@nhs.net) | | | | | | | | | |