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| **GOOD NEWS FAMILY CARE INITIAL REFERRAL FORM**  Please send this form to [mail@gnfc.org.uk](mailto:mail@gnfc.org.uk) or post to Charis House, Hardwick Square East, Buxton, SK17 6PT | | | | | | | | | | | | | | | | |
| **Residential Recovery Centre** | | **Residential Family Centre** | | | | | | **Community Drop-in groups** | | | | | | | **Work-skills Projects** | |
|  | |  | | | | | |  | | | | | | |  | |
| **Applicant Details** | | | | | | | | | | | | | | | | |
| Name of individual being referred: | | | | | | | | | | Date of referral: | | | | | | |
| Address: | | | | | | | | | | | | | | | | |
| Date of birth: | Contact number/s: | | | | | | | | | | | | | NI Number: | | |
| Name of other family members included in this referral | | | | | | Date of birth | | | | Gender | | | School/Nursery | | | |
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| Name of partner/father to children: | | | | | | Address: | | | | | | | | | Is there DV with this individual? | |
| Next of Kin: | | | | | | Relationship: | | | | | | | | | Contact number: | |
| **Referral Information –** please add additional information on the reverse of this page if necessary | | | | | | | | | | | | | | | | |
| Reason for referral and details of what the applicant needs support with: | | | | | | | | | | | | | | | | |
| **Has the individual experienced:** | | | **Current** | | **Previous** | | **No history** | | **Unknown** | | **Further Information** | | | | | |
| Domestic violence | | |  | |  | |  | |  | |  | | | | | |
| Substance misuse difficulties | | |  | |  | |  | |  | |
| Alcohol misuse | | |  | |  | |  | |  | |
| Mental health issues | | |  | |  | |  | |  | |
| Self-harm | | |  | |  | |  | |  | |
| Refuge/supported accommodation | | |  | |  | |  | |  | |
| Medical issues | | |  | |  | |  | |  | |
| Have a disability | | |  | |  | |  | |  | |
| Criminal behaviour | | |  | |  | |  | |  | |
| Please give details of current medication | | | | | | | | | | | | | | | | |
| Is/are the child/ren subject to a:Child in need planChild protection plan  Court order  If yes, please provide further details:  Please give details regarding any safeguarding issues: | | | | | | | | | | | | | | | | |
| Please include any additional information relevant to this referral, you made use a second page if necessary. | | | | | | | | | | | | | | | | |
| **Professionals involved: Name** | | | | **Agency** | | | | | | | | | | **Contact details** | | |
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| **Name of referrer:** | | | | **Contact Number:** | | | | | | | | Agency: | | | | Self-referral |
| *The referring agency agrees to underwrite the funding of this referral, including services, food, rent etc. should the individual fail to pay or prove to be ineligible for benefits ie Housing benefit, or if additional care components are required for which funding is unavailable.* | | | | | | | | | | | | | | **Signed:**  **Date:** | | |

**Member of staff receiving referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Referral accepted**  **Referral declined**