TEAM AROUND THE FAMILY PROFESSIONALS REFERRAL

Early Support for Families

Referrer details:*

Form completed by:	
Job tile/role:	
Agency:	
Contact number:	
Address:	
Email:	
Date:	

Guidance for completing the form:

- Please ensure all fields marked with a * are completed or this will cause delay regarding the referral being processed and could result in the referral being returned to you.
- Where possible ensure this form is completed with the family and provide them with a copy.
- Provide as much information as possible in order to prevent delay in the decision making process.

YOU MUST HAVE CONSENT FROM THE FAMILY TO REFER TO TAF

The family must be made aware that this referral and its contents will be discussed at a Multi-agency panel in order to make a decision regarding support. If you are unsure of the TAF processes please contact us.
Ensure the family know and understand what support TAF offer to assist an informed decision being made, if you require support to make a referral we are always happy to help, please call us or email on the numbers/ email address included in this form

Consent Form

Consent statement for information storage and information sharing:
We will treat your information as confidential and we will not share it with any other organisation unless we are required by law to share it or unless you or a child/young person will come to some harm if we do not share it. In any case, we will only ever share the minimum information we need to share.

I understand the information that is recorded on this form and that it will be stored and used for the purpose of providing services to me and my family.

I understand that in order to provide services some information will be shared with a variety of agencies including social services.

I understand that other agencies including social services will share information with the Team around the Family Service and provider agencies, for the purpose of appropriate services being offered.

Signed (Parent/ Carer):		**Print Name:**		**Date:**	
Signed (Parent/ Carer):		**Print name:**		**Date:**	

If the child(ren) or young person(s) included within this referral are old enough to be able to understand and consent to this referral, their signature should be provided below.

Signed (child/ young person)		**Print Name:**		**Date:**	
Signed (child/ young person)		**Print Name:**		**Date:**	

Exceptional circumstances: concerns about significant harm to infant, child or young person.

If at any time during the course of this process you are concerned that an infant, child or young person has been harmed, abused or is at risk of being harmed or abused, you must follow the All Wales Child Protection Procedures.

Team around the Family Contact information:

If you would like further information regarding support please contact us on the below number or email and one of our friendly team members will assist you with your enquiry.

☎ 01633 644344/ 644641

✉ **jaff@monmouthshire.gov.uk**

Team around the Family
Monmouthshire County Council
PO BOX 106
Caldicot
NP26 9AN

Basic Details

CHILD/YOUNG PERSON AND SIBLING DETAILS*					
Name*	**DOB***	**Address***	**Postcode***	**Ethnicity**	**School/Nursery/ Playgroup***

CHILD/YOUNG PERSONS MAIN PARENTS/CARERS LIVING IN HOUSEHOLD*						
Name*	**DOB***	**Relationship to child/young person***	**First Language**	**Ethnicity**	**Contact number***	**Parental Responsibility***
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐

CHILD/YOUNG PERSONS PARENTS/CARERS NOT LIVING IN HOUSEHOLD*						
Name*	**DOB***	**Relationship to child/young person***	**First Language***	**Ethnicity**	**Contact Number***	**Parental Responsibility***
						Yes ☐ No ☐
						Yes ☐ No ☐

Other household members (including non-family members)*		
Name	**DOB**	**Relationship to child**

Referral Information

Please tick in which areas the family would want/ would benefit from assistance or support*

Training, skills, employment, income	Yes ☐	Relationships and Social lives	Yes ☐
Engagement with school/formal education	Yes ☐	Behaviour	Yes ☐
Achievement	Yes ☐	Parenting Skills	Yes ☐
Emotional health / wellbeing	Yes ☐	Parenting Capacity	Yes ☐
Physical Health	Yes ☐	Home Environment	Yes ☐

Please provide information about why the family may need support in the above stated areas (*The reason for the referral)**

What would you and the family like to achieve by making this referral?*

Does the child appear to be safe from harm?* Yes ☐ No ☐ Not Sure ☐

If no or you are not sure, what are your concerns?*

Disability information*
Does any member/s of the family have a disability: **Yes** ☐ **No** ☐ *If yes please provide information*

Who is already involved?

Please record details of any professionals who are already involved with the family.

Key agencies who are also working with the child, young person of their family (if known):					
School/ college*		Name		Phone: Email:	
GP*		Name		Phone: Email:	
Other health professionals		Name		Phone: Email:	
Agency		Name		Phone: Email:	
Agency		Name		Phone: Email:	
Agency		Name		Phone: Email:	

Return to post address: Team around the Family, Monmouthshire County Council, PO BOX 106, Caldicot, NP26 9AN

Email the completed form to: jaff@monmouthshire.gov.uk

REFERRERS PLEASE NOTE: You are required to scan and email the signature sheet to the TAF Team or send it via post to the TAF address in the contact information section of this form.