



CONFIDENTIAL REFERRAL FORM

Form to be completed in partnership with parent/carer

Please note the family must have at least one child under the age of 5 years.

CLOWNS are able to work with families for 1 hour a week for 12 weeks after which a review will take place. If further time is needed another 12 weeks will be allocated.

Date		Name of Doctor	
Name of parent/carer		Address of Doctor	
Address			
		Name of Health Visitor	
		Name of Midwife	
		Please list other agencies involved	
Postcode			
Telephone No.			
Name of child	Date of birth		
		Name groups attended by your child (with or without parent/carer)	
Registered disabled	Yes	No	Referred by
			Agency
			Self
On Child Protection Register	Yes	No	Address
Preferred language			Postcode
Ethnic origin			Telephone No.

In order for CLOWNS to give the appropriate support, please tick the boxes below indicating what your child's/the family's needs are and what you would like to gain from CLOWNS' involvement.

We cannot promise to solve all your problems but our staff can provide a listening ear and assist you in getting any other professional help you may need.

CHILD'S NEED	✓	PLEASE TELL US WHY THIS IS A NEED
Learning to play		
Learning to behave		
Learning to share		
Help with speech & communication		
A child under 5, with several siblings, who needs additional support		
Other needs: Please describe		
FAMILY'S NEED	✓	PLEASE TELL US WHY THIS IS A NEED
You/the family new to the area		
Lack of transport, difficulty in accessing services for the family		
Feelings of isolation, no-one to talk to		
Coping with more than one child with at least one under 5		
Other needs: Please describe		

Have you completed a CAF (Common Assessment Framework) form? YES No

Have you completed an E Start form from your local Children's Centre? YES No
(Please tick as applicable)

Parent/carer signature

Agency referrer signature

Please sign below if consent is given for CLOWNS to liaise with other agencies:

Parent/carer signature