**CARING DADS REFERRAL FORM**

**CLIENT INFORMATION:**

Father’s Name:

Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (m/d/y) \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of residency in the UK \_\_\_\_\_ years

Language (s) spoken / Need for interpreter?\_\_\_\_\_

Does this client experience challenges in reading or writing English? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this client have substance abuse issues the might impact group? Yes  No

If yes, explain\_\_\_

Does this client have mental health issues that might impact group? Yes  No

If yes, explain \_\_\_

**Mother’s Name**: (If more than one please list)

Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (m/d/y) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language (s) spoken at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parental Relationship: Together  Separated:

Child(ren):

Last Name First Name DOB & Mother

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REFERRAL INFORMATION:**

Name of worker/officer: Click here to enter text.

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:Click here to enter text.

**Reasons for Referral**: \_\_\_\_\_

**Goals for Participation in Caring Dads:** \_\_\_\_\_\_

**Do you have consent to submit a referral from your client? YES  NO**

**(If no, the referral cannot be considered)**

**Is mum aware of the referral? YES  NO**

**(If no, the referral cannot proceed without a clear rationale**

**Has a CAADA DASH Assessment been completed? Date:** Click here to enter text. **Score:** Click here to enter text.

**Is mum in contact with a domestic abuse support service? YES  NO**

**If yes, who is her worker?** Click here to enter text.

**By submitting the referral you agree to keep this case open to services for the duration of the 17 week course, ending in May 2019.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please email form to:** [**caringdads@cambridgeshire.gov.uk**](mailto:caringdads@cambridgeshire.gov.uk)