**WHO’S IN CHARGE REFERRAL FORM**

PLEASE READ THE BELOW BEFORE COMPLETING THE REFERRAL FORM

**Who’s in Charge?** is a 9-week child to parent violence (CPV) programme aimed at parents **whose children are aged between 8 – 18 years old** and are **being abusive or violent toward them or who appear out of parental control**.  The structure of the programme consists of 8 two-hour sessions with a two-month follow up which the parent(s) must be able to commit to. **Parental consent must also be gained before completing the referral.**

Please tick here if the family being referred meet the above criteria

Has parental consent been received

|  |  |
| --- | --- |
| **Information about the person making the referral** | |
|  | |
| Date of referral: |  |
| Name of Programme: |  |
| **Please ensure all below sections are completed** | |
| Referrer’s name (if applicable) |  |
| Organisation name (if applicable) |  |
| Role/ job title (if applicable) |  |
| Contact number |  |
| Contact email |  |

**Information about the parent(s) wishing to complete the programme (if an additional parent is accompanying, please specify this in parent 2 section).**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent 1** |  | **Parent 2 (if applicable, state relationship to child/ren)** |  |
| First name |  | First Name |  |
| Last name |  | Last Name |  |
| Other names |  | Other Names |  |
| What do they like to be called? |  | What do they like to be called |  |
| DOB |  | DOB |  |
| Parental responsibility of Child? ‘x’ if yes. |  | Parental responsibility of child? ‘x’ if yes. |  |
| **Current address** |  | **Current address (if different to Parent 1)** |  |
| **Contact Info** |  | **Contact info** |  |
| Contact Number |  | Contact Number |  |
| Is it safe to leave message Y/N |  | Is it safe to leave a message Y/N |  |
| Email |  | Email |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Details of all **children** in the household where the child/YP is living (start with most challenging child first) | | | | | | | | | | |
| **Name** | | **DOB** | | **Gender** | | **Ethnicity/Language** | | **SEND / Diagnosed condition** | | **School/ nursery** |
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| Details of all **adults** in the household where the child/YP is living | | | | | | | | | | |
| **Name** | **DOB** | | **Gender** | | **Ethnicity/Language** | | **Disability (if yes, please specify)** | | **Relationship to child** | |
|  |  | |  | |  | |  | |  | |
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**Please complete with the client:**

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| --- | --- | --- | --- | --- | --- |
| **Child’s Behaviours** | | | | | |
| Guidance: How often, in the last 2 months (or the last 2 months that you were together) have these behaviours happened? | | | | | |
| **To me** | Never | Once or twice | A few times | Once or twice a week | Daily or almost daily |
| Hit |  |  |  |  |  |
| Thrown things at |  |  |  |  |  |
| Pushed or grabbed |  |  |  |  |  |
| Yelled at |  |  |  |  |  |
| Verbally abused |  |  |  |  |  |
| Destroyed property |  |  |  |  |  |
| **To my partner**  **(if applicable)** | Never | Once or twice | A few times | Once or twice a week | Daily or almost daily |
| Hit |  |  |  |  |  |
| Thrown things at |  |  |  |  |  |
| Pushed or grabbed |  |  |  |  |  |
| Yelled at |  |  |  |  |  |
| Verbally abused |  |  |  |  |  |
| Destroyed property |  |  |  |  |  |
| **To siblings** | Never | Once or twice | A few times | Once or twice a week | Daily or almost daily |
| Hit |  |  |  |  |  |
| Thrown things at |  |  |  |  |  |
| Pushed or grabbed |  |  |  |  |  |
| Yelled at |  |  |  |  |  |
| Verbally abused |  |  |  |  |  |
| Destroyed property |  |  |  |  |  |

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| **Impact of the behaviour:**  Guidance: **SD** Strongly Disagree **D** Disagree **N**  Neutral **A** Agree **SA** Strongly Agree | | | | | |
|  | **SD** | **D** | **N** | **A** | **SA** |
| I feel able to cope with my child’s behaviour |  |  |  |  |  |
| I think things are getting better |  |  |  |  |  |
| I feel stressed and/or anxious |  |  |  |  |  |
| I feel guilty about my child’s behaviour |  |  |  |  |  |
| I feel depressed or very unhappy |  |  |  |  |  |
| I feel my health is suffering |  |  |  |  |  |
| I have good support with this issue |  |  |  |  |  |
| **Please give details of issues within the family environment, including any significant events that have led to making the referral.** | | | | | |

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| **Additional information about the child:** | **Yes** | **No** | |
| **Has your child been abused in the past?** |  | |  |
| **Has your child witnessed or heard domestic abuse?** |  | |  |

**Client equalities monitoring**

**Client 1:**

|  |  |  |
| --- | --- | --- |
| Client Gender | Female | Male |
| Do they have any kind of disability?  (please tick any that apply) | Physical  Learning  Mental Health  Deaf/ hearing impaired  Blind/ visually impaired  Something else:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| How would they describe their ethnicity? | | |
| White British  White Irish  White Gypsy or Irish Traveller  Any other White background  Asian British  Asian Indian  Asian Pakistani  Asian Bangladeshi  Any other Asian background  Chinese  Arab | White and Black Caribbean  White and Black African  White and Asian  Any other mixed/ multiple background  Black British  Black African  Black Caribbean  Any other Black background  Other (please specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| Do they have a faith/ religion? | | |
| No religion  Bahai  Buddhist  Christian  Hindu  Jewish  Jain | Muslim  Shinto  Sikh  Zoroastrian  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| What is client’s nationality? |  | |

**Client 2 (if applicable):**

|  |  |  |
| --- | --- | --- |
| Client Gender | Female | Male |
| Do they have any kind of disability?  (please tick any that apply) | Physical  Learning  Mental Health  Deaf/ hearing impaired  Blind/ visually impaired  Something else:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| How would they describe their ethnicity? | | |
| White British  White Irish  White Gypsy or Irish Traveller  Any other White background  Asian British  Asian Indian  Asian Pakistani  Asian Bangladeshi  Any other Asian background  Chinese  Arab | White and Black Caribbean  White and Black African  White and Asian  Any other mixed/ multiple background  Black British  Black African  Black Caribbean  Any other Black background  Other (please specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| Do they have a faith/ religion? | | |
| No religion  Bahai  Buddhist  Christian  Hindu  Jewish  Jain | Muslim  Shinto  Sikh  Zoroastrian  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| What is client’s nationality? |  | |

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| --- | --- | --- |
| Is there any social care involvement in this case? | Yes | No |
| *(Please provide details including any plans)* | | |
| Name of allocated worker and contact details  *(if relevant)* |  | |
| Does client have additional needs? | Yes | No |
| If yes, please provide an overview of support needs | | |

**To submit this referral please email it to advice@ndas-org.co.uk**

**If you have any queries, please email** **advice@ndas-org.co.uk** or call **0300 0120 154**.