

Parenting Project Wellbeing Referral

The Parenting Project aim is to improve the long term mental health and wellbeing of parents and their children / young people throughout Warwickshire. We take a ‘whole family’ approach to mental health which means that we work with families to identify their needs and possible solutions and work in partnership with them to enable them to tackle the issues.

This is a request for support for children and young people aged 0-19 years, (25 for SEND), and their family.

In order for us to deal with your referral effectively please provide as much information as you can.

The services included in the Pathway are:

**Family Wellbeing Facilitators**: Working with parents and individual children aged 0-19 (25 SEND), providing individually tailored support, to enhance and support the mental health and wellbeing of the whole family.

Examples of need include: behaviour management strategies, low mood, anxiety, isolation, loneliness, transitional changes, family relationships and dynamics.

**Parent Mentoring:** Parent Mentors are trained volunteers, who provide friendly, informal support, encouragement and guidance with families in a non-judgemental way.

Examples of need include: **LOW LEVEL**; emotional wellbeing, confidence, isolation, loneliness, aspirations for the future.

**Counselling Service**: We offer up to 18 weekly sessions of counselling to parents and carers of children 0-19 (25 SEN) living in Warwickshire. We are a general counselling service and parents/carers can explore anything that feels important to them. To make a referral for counselling please visit [live.sgioba.com/parentingproject/register/](https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Flive.sgioba.com%2Fparentingproject%2Fregister%2F&data=04%7C01%7Csallyannegroves%40warwickshire.gov.uk%7C908a03d6f9364052b07508da01062381%7C88b0aa0659274bbba89389cc2713ac82%7C0%7C0%7C637823423128367116%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=HQF2CguA9PHYZyjAnIaoy2%2Fxd29WCxUrtc7lM0d1GWQ%3D&reserved=0) or email counselling@parentingproject.org.uk for more information.

If you would like assistance with completing this referral form please email familywellbeing@parentingproject.org.uk

Please return completed referral to familywellbeing@parentingproject.org.uk

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| **Service requested - please tick** |
| Family Wellbeing Team  |  | Parent Mentor  |  |

**Whilst a client/family may self-refer, it is essential if you are referring on behalf of a client/family you must gain consent from the Parent(s) for the referral being made.**

**Child and Family Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Child(ren) or Young Person(s) Name(s): | D.O.B(s): | Gender\*prefer not to say | Ethnicity \*prefer not to say |
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| --- | --- | --- | --- |
| **Parent(s) and/or Carer(s) Name:** (Who Lives With The Child) | D.O.B | Gender\*prefer not to say | Ethnicity\*prefer not to say |
|  |  |  |  |
| Family Address, including postcode. | Home Contact Number:Mobile Contact Number:Email Address: |
| **Other Parents Name:** | D.O.B (If known) | Gender (If known)  | Ethnicity(If known)  |
|  |  |  |  |
| Home Address: | Home Contact Number:Mobile Contact Number:Email Address: |

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| --- | --- |
| **Current School(s) placement:** |  |
| **Childs Name** | **Date of Birth** | **School** |
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| **Please Briefly Describe The Current Situation For The Family. Include Any Additional Information That Will Support This Referral:** |
| **What do you feel the family needs to achieve?** |

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| **Please tick all areas that you would like help with:** |
| **Child(ren)/ Young People** | **Parents/carers** | **Family/environmental** |
| Health  |  | Developing positive mental health |  | Preparing for new baby/ routines |  |
| Developing Friendships |  | Parenting skills |  | Encouraging good Family relationship |  |
| Social skills |  | Developing friendships and a network of support, opportunities to meet others |  | Finance/benefits/ Housing |  |
| Wellbeing |  | Managing Barriers: i.e. disability, illness, and language. |  | Support if there is Domestic abuse |  |
|  **Other** (please specify): |

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| --- |
| Date of Referral…………………………………………. |

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| --- | --- |
| **Professional Referral**Name of Referrer;  | Agency: |
| Address, including postcode: | Relationship To The Family: |
| Contact Number:  | Contact Email: |
| **Are The Family Subject To An Early Help Single Assessment**? YES or NO**Key Worker Details:** |



 ***Thank You for Completing This Form***