The Early Intervention Parenting Programme (EIPP)

Referral Form

Incredible Years – September 08 groups

Full Name of Child Concerned:
Male/Female

Date of Birth: **Age:** **School Year Group:**

In order to ensure that this programme is reaching all members of the community we would be grateful if you would tell us your child's ethnicity.

Child's Ethnicity					
White:	White - British		Asian:	Bangladeshi	
	Irish			Indian	
	Turkish/ Turkish Cypriot			Pakistani	
	Greek/ Cypriot			Any Other Asian Background	
	Traveller of Irish Heritage		Mixed:	White & Black African	
	Eastern European			White & Black Caribbean	
	Any Other White Background			White & Asian	
Black:	African - Congolese			Mixed Other	
	African - Somali		Other	Kurdish	
	African - Other		Ethnic	Vietnamese	
	Caribbean		Groups:	Chinese	
	Black - British			Orthodox Jewish	
	Any Other Black Background			Any Other Ethnic Background	

Full Name of Parent/s or Carer attending:

Relationship to the child:

Address(es):

Tel Numbers/Mobile(s):

Marital Status of parents/carer attending		Who does the child live with?	
Single		Mother	
Married		Father	
Living with partner		Both Parents	
Separated		Carer (please specify)	
Divorced		Other (please specify)	
Widowed			

Will parent/s need an interpreter? If so, for which language?

What language/s does the family speak at home?

Can parent/s make use of written handouts?
Yes **Yes with assistance** **No**

Have you given and talked through with the parent/s the EIPP Parent Information Leaflet?
Yes **No**

Reason for referral including parent's description of the problem (please give example if possible):

Brief description of child's behaviour in school/nursery, including academic progress if known (please give an example/ how long has this been happening):

Does the child have special educational needs? Please give details and whether statemented.

Does the child receive free school meals?
Yes **No**

Relevant background information (medical problems, family concerns, including any difficulties regarding other young people/children in the family):

Age, name and gender of ALL siblings - please indicate which one/s will be using the crèche:

Names of sibling	M/F	Age	Using Crèche
1.			
2.			
3.			
4.			
5.			
6.			

Please specify any special medical/other needs for children attending the crèche e.g. allergies

- **Please state other known agencies involved e.g. Health visitor/playgroup:**

- **GP name and address:**

- **School/nursery name and address, phone number:**

- **Is a social worker involved (please give name and contact details)?**
  Yes No

- **Is the child on the child protection register? Please state the category if known.**
  Yes No

- **Please include any other information that you think it would be helpful for us to know including agencies that might be supporting other children/young peolpe in the family:**

I have read through this referral form and agree to being referred to a group

Parent's Signature: ---------- Date:

Or

I have read through this form with the parent/s who has/ve agreed for a referral to EIPP

Referrers Signature: ---------- Date:

PLEASE ENSURE YOU COMPLETE THE FOLLOWING SECTION

Referrers Details

Name: **Profession:**

Organisation:

Address:

Tel. Nos: **Email:**

YES I would like an emailed acknowledgement when EIPP have received this referral ☐ (please tick)

These details will be kept on a confidential database in the EIPP office at the Ann Tayler Centre

Thank you for filling out this form

Please send completed referral form to:

EIPP, Ann Tayler Children's Centre, 1-13 Triangle Road, E8 3RP
Office Manager: Tel: 0207 275 6040 Fax: 0207 275 6048
(Please do not email a completed referral form as this contravenes the Data Protection Act)