CLIENT REFERRAL FORM

For use by a professional wishing to refer a client to a Brilliant Parents training programme

Please complete in BLOCK CAPITALS

Date of referral	

REFERRING ORGANISATION DETAILS

Name	
Address	
Postcode	
Referrer's Name	
Job title	
Telephone number	
Email	
How did you hear about Brilliant Parents?	

CLIENT DETAILS

Title (please indicate)

Mr	Mrs	Ms	Miss	Dr	Other	If other, please state

First name	
Last name	
Address	
Postcode	
Mobile Number	
Landline Number	

CLIENT DETAILS continued									
Email									
Gender	Male		Female		Prefer not to say				
Age group									
Under 18		18-24		25-34		35-44			
45-54		55-64		65+					
Ethnicity - please tick ONE category									
White									
English / Welsh / Scottish / Northern Irish / British		Irish							
Gypsy or Irish Traveller		Any other White background							
If any other White background, give details									
Mixed / Multiple ethnic groups									
White and Black Caribbean		White and Black African							
White and Asian		Any other Mixed/ Multiple ethnic background - give details							
Asian / Asian British									
Indian		Bangladeshi							
Pakistani		Chinese							
Any other Asian background - give details									
Black / African / Caribbean / Black British									
African		Caribbean							
Any other Black / African / Caribbean background - give details									

Other ethnic group							
Arab		Any other ethnic group - give details					
Primary Language							
If English is the client's second language, please indicate what you think their level of confidence is, in UNDERSTANDING English (Tick ONE box)	Fluent		Good		Beginner		
If English is the client's second language, please indicate what you think their level of confidence is, in SPEAKING English (Tick ONE box)	Fluent		Good		Beginner		
Does the client require any assistance with literacy?	Yes		No				
Does the client have a learning difficulty?	Yes		No				
Does the client have a long-term health problem? If yes, give details	Yes		No				
Does the client consider themselves to a have a disability? If yes, give details and state whether they are are registered disabled or not.	Yes		No				
Does the client have any additional needs that we need to be aware of (e.g Anger management / Child Protection Issues)? If yes, give details	Yes		No				
What is the client's relationship to the child concerned? Please tick ONE box							
Parent		Grandparent		Foster Carer		Carer		Other	
If other, give details							

Please tick as many of the following boxes as apply to the client									
Biological parent		Adoptive parent		Grandparent		Step-parent			
Foster Carer		Married living with spouse		Co-habiting with a partner		Lone Parent			
Other - give details									
What parenting support has the client previously received?									

Please list details about all the children in the client's care					
Child's Name	Date of birth	Age	Gender	Ethnicity	Nursery/ School Child Attends

Do any of the children have any educational or learning needs (e.g. a statement of needs or behavioural support plan)? If yes, give details	Yes		No	
Do any of the children have emotional or behavioural issues? If yes, give details	Yes		No	
Are any of these children on the Child Protection or Child in Need registers? If yes, give details	Yes		No	

Are any of the children Looked After children? If yes, give details	Yes		No	

Which programme(s) would you recommend that the client attends? Please tick all that apply				
Triple P Group Course (for parents with 2-12 year olds) 6 sessions	Yes		No	
Triple P Group Seminar (for parents with 2-12 year olds)	Yes		No	
Triple P Teen Course (for parents with teens 11+) 6 sessions	Yes		No	
Triple P Teen Seminar (for parents with teens 11+)	Yes		No	
Triple P Stepping Stones Course (For parents with children with additional needs) 8 sessions (for parents with 2-12 year olds)	Yes		No	

What are the client's goals?	

Does the client have any concerns regarding their relationship with their partner / husband / wife that might impact the child / children? If yes, give details	Yes		No	

Is the client currently experiencing difficulties with their child / children? If yes, give details	Yes		No	

On a scale of 0-10, how committed to implementing change do you think the client is? (0 = least likely, 10 = most likely) Please tick ONE box											
0		1		2		3		4		5	
6		7		8		9		10			

Additional Comments

For Brilliant Parents Office use only				
Added to ‘Waiting List’?	Yes		No	
Signposted on?	Yes		No	
If yes, please give details				
Date called parent / carer				
Date emailed/wrote to parent / carer				
Outcome				
Additional Communication				