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| --- | --- | --- |
| **OFFICE USE ONLY**  | **KW** |  |
| Date Referral received: |  |
| Date of acknowledgement: |  |
| Service Required: |  |
| Contact arrangements: |  |
| Does Nrp have PR? |  |
| Fee payer: |  |

**Text  Description automatically generated****HANDOVER REFERRAL FORM**

|  |
| --- |
| **1. What are the principal reasons for wanting this contact or service(s)?** |
| **a.** |  |
|  |
| **b.** |  |
|  |
| **c.** |  |
|  |

**2. Child/ren (**Please see Ethnic Codes)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name(s)**  | **Age** | **Date of Birth** | **Male/Female** | **Ethnicity** |
|  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- |
| 1) Black African | 2) Afro Caribbean | 3) Black Mixed Percentage | 4) Black British | 5) White UK | 6) UK Irish |
| 7) Polish | 8) Bengali (Bangladeshi) | 9) Indian | 10) Pakistani | 11) Chinese | 12) SE Asian (Vietnamese) |
| 13) Arabic | 14) Turkish | 15) Cypriot | 16) Turkish/ Cypriot  | 17) European  | 18) Other (inc. mixed percentage) |

 |
| **3. Adult requesting contact** | **Name:** |  |
|  | **Relationship to Child/ren** |  |
| Does this person have legal parental responsibility? | Yes 🗆 No 🗆 (please clarify) |
| Address: |  | Mobile | Email |
|  |  |
|  |  |  |
| Solicitor’s name: |  | Name of Practice: |  |
| Email |  | Landline/Mobile |  |
|  |  |  |
| **4. Adult the child/ren reside with** | **Name:** |  |
|  | **Relationship to Child/ren** |  |
| Does this person have legal parental responsibility? | Yes 🗆 No 🗆 (please clarify) |
| Address: |  | Mobile  | Email  |
|  |  |
|  |  |  |  |
| Solicitor’s name: |  | Name of Practice: |  |
| Email: |  | Landline/Mobile: |  |
|  |
| **5. Has there been any professional involvement in Child Contact Proceedings?**  |
| a. i.e., CAFCASS, Social Services ? | Yes 🗆 | No 🗆 |
| b. Are they currently involved ? \*Continue overleaf if you require more space | Yes 🗆  | No 🗆 |
| Name: |  | Position: |  |
| Email: |  | Contact number: |  |
| Name: |  | Position: |  |
| Email: |  | Contact number: |  |
| Name: |  | Position: |  |
| Email: |  | Contact number: |  |
| c. When/Where did contact last take place. Who with? |  |
| d. Is there a court order relating to the contact arrangements?  | Yes 🗆  | No 🗆   |
| * If ‘Yes’, please send a copy of the current Court Order with your referral form
 | **Who is the fee payer?** |  |
| **What are the Child Contact Arrangements to be facilitated (Duration, Frequency, how many sessions)?** |
|  |
|  |
|  |
|  |
| g. What is the next court date (if any)? \* Please keep us updated |  |
| h. What type of Court Proceeding? |  |

|  |
| --- |
| **6. Arrival at the Child Contact Centre** |
| a. Are the parents willing to meet if necessary? | Yes 🗆 | Yes 🗆 |
| b. Are there any non-molestation Orders currently in place?  | Yes 🗆 Exp date: | No 🗆 |
| c. Will the resident be bringing and collecting the child/dren from the Centre?  | Yes 🗆 | No 🗆 |
| d. If ‘No’, who will be bringing / collecting the child/ren?\* they will require ID  |  |
| e. What is the preferred date of first contact at the Centre? |  |
| f. Additional people “allowed” to participate in contact at | the Centre (2 max) (Subject to Court Order /Professional Representative) |
| Name: | Relationship to child: |
|  |  |
|  |  |
|  |  |
|  |
| **7. Health & Medical Requirements** |
| 1. Do any of the CHILDREN have any illness, allergy, impairment, special needs or medical requirements? If ‘Yes’, please give details
 | Yes 🗆 | No 🗆 |
|  |
|  |
| 1. Do any of the adults involved suffer from long-term physical / mental illness or impairment? If ‘Yes’, please give details
 | Yes 🗆 | No 🗆 |
|  |
|  |
| c. Has this family ever used another Child Contact Centre?  | Yes 🗆 | No 🗆 |
| If ‘Yes, please give details (this Centre may be contacted). |
| Name of Centre | Email | From | To | Why was contact stopped? |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Please provide us with any information or concerns you may have that will enable us to provide an effective, safe, trouble or incident free hand over session.** |

In receipt of this referral a Family Support Worker will be in contact within 7 business days.

**N.B**. Only dates and times of family’s attendance will be recorded during each visit.

If it is felt that anyone using the Child Contact Centre proves to be of risk to others or verbally abusive, they will be asked to leave the premises and contact will be immediately suspended pending investigation.

Please return this form to: **VOICE OF THE CHILD**

Address: Unit 8,Beacontree Plaza, Gillette Way, Reading, RG2 0BS

Email: admin@voiceofthechild.org