Healthy Relationships Awareness Centre
Referral form

*Mandatory

Please indicate which programme you would like to refer to:	
***Building Safer Families Programme** – Supporting expectant partners into a healthy relationship	Yes / No
***Date of referral:**	

Your personal information				
Full name of Service User				
Date of birth				
Current Address, including postcode				
Home number				
Mobile number				
Email address				
Preferred contact method	Home number	Mobile number	Email	Post
Are there any specific times to make contact?				
Are you currently living with your partner?	Yes / No / Unknown			
Length of Relationship				
Diversity Information				
Sex				
Marital status				
Ethnicity				
Disability				
Religion				
Sexuality				
Language				
Is a translator required	Yes / No / Unknown			
If a translator is required, please specify language				

***Vulnerabilities**	
Mental health	Yes / No / Unknown
Substance/alcohol misuse	Yes / No / Unknown
Learning difficulties	Yes / No / Unknown
Physical health issues or disability	Yes / No / Unknown
Self harm or suicidal attempts (please provide additional information)	Yes / No / Unknown
Criminal convictions	Yes / No / Unknown
Are there any risks of harm to children	Yes / No / Unknown

***Childrens Information**

Child name	**CP/CIN (Y/N)**	**Date of birth**	**Bio/Non-Bio to FIP Service User**	**Gender identity**	**Disability**	**Address (if different from) SU**	**Ethnicity**	**Relationship to SU being referred (Son, Daughter, Step/other)**

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***Expected due date of child?**	
***Other professional Involved in supporting your family**	

***Support required**
Please provide additional information and reason for referral/current situation. Please comment on motivation to change and any known incidents.

***Partner/ Ex Partner Details**				
Is the person aware of the referral and given consent	Yes / No			
How was consent obtained	Verbally/In writing			
Full name				
Date of birth				
Address, including postcode				
Home number				
Mobile number				
Email address				
Preferred contact method	Home number	Mobile number	Email	Post
Are there any specific times to make contact?				
Is the Partner/ Ex Partner currently living with you?	Yes / No / Unknown			
Length of Relationship				

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GP/Medical Practice Details	
Diversity Information	
Gender identity	
Marital status	
Ethnicity	
Disability	
Religion	
Sexuality	
Language	
Is a translator required	Yes / No / Unknown

***Childrens Information**								
Child name	**CP/ CIN Y/N**	**Date of birth**	**Bio/Non-Bio to Service User**	**Gender identity**	**Disability**	**Ethnicity**	**Address if different from Service User**	**Relationship to Partner (Ex/Other) being referred (Son, Daughter, Step/other)**

***Vulnerabilities Partner / Ex Partner**	
Mental health	Yes / No / Unknown
Substance/alcohol misuse	Yes / No / Unknown
Learning difficulties	Yes / No / Unknown
Physical health issues or disability	Yes / No / Unknown
Self harm or suicidal attempts (please provide additional information)	Yes / No / Unknown
Criminal convictions	Yes / No / Unknown
Are there any risks of harm to children	Yes / No / Unknown

***Other professional Involvement with Partner / Ex partner**	