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| ***Fathers Service*** *Therapeutic and Parenting Support for Dads****Referral Form*** |  |

**Please complete this form as fully as possible and email to** navraj.sidhu@oasisproject.org.uk

Fathers will be asked to complete an assessment prior to work commencing.

Please call Navraj Sidhu on 07712 528 494 if you wish to discuss a referral.

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| **Referrer Details** |
| **Name**:  |
| **Agency**:  |
| **Address**:  |
| **Telephone number**:  |
| **Email**:  |
| **Please confirm that this referral has been discussed with the father** Yes/ No |
| **Date of Referral**:  |

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| **Father Details :** | **Mother/Other carer Details:** |
| **Name**:  | **Name:** *Please confirm that Mother has provided consent for this information to be shared:* ***Yes/No*** |
| **Date of Birth**:  | **Date of Birth**:  |
| **Telephone**:  | **Telephone**:  |
| **Address**:  | **Address**:  |
| **Email**: *Please provide an email address.* | **Email:**  |
| **State if the Father is in a relationship, co-habiting or separated:**  | **State if the Mother is in a relationship, co-habiting or separated:** |
| **Drug and Alcohol issue (current and/or historic):**  | **Drug and Alcohol issues (current and/or historic):** |
| **Details of Children** |
| **Details of the children including their names/DOB and address(es)**  | **Are family involved with Children’s Services? Are the children subject to a CIN or CP plan?**sf |
| **Details of children’s living circumstances.** Father’s access/care arrangements (if known) ? Have there been any Court Proceedings? |
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| **Reason for Referral:** (Details of how you think the Fathers Service will support the father/children/family) |
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| **Agencies currently ,or historically, involved with the Father and/or children :**  |
| Agency 1:Agency 2:Agency 3:Agency 4 |
| **Hopes and goals of Fathers Service** |
| **Father’s hopes or expectations:** |
| **Please Provide any other information that you consider important or relevant.**  |
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