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| Parent And Infant Relationships Team¯For expectant parents/carers, and parents/ carers of infants aged 0-2 years¯ |

**Confidentiality**

If you are a professional, please discuss this referral with the parent(s) or carer(s). It may be necessary to share information with other professionals if PAIR Team is deemed not appropriate at triage, this is so we can offer the best service to the family. During the course of their care, some details may be recorded digitally. For your protection, the use of this data is controlled in accordance with the Data Protection Act, 1998.

**Please ensure the risk factor questionnaire is completed within this referral form.**

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| **SECTION 1 – PARENT/CARER’S NAME** |
| Name: |  Date of birth: | Parental responsibility: Yes/No |
| Gender: | Ethnicity: | Religion: |
| Relationship to infant: | Mobile number: |
| Address: | Email address: |
| Gestation:  | Estimated Due Date: |
| **2nd PARENT/CARER’S NAME** |
| Name: | Date of birth: | Parental responsibility: Yes/No |
| Gender:  | Ethnicity: | Religion: |
| Relationship to infant: | Mobile number: |
| Address: | Email address: |
| Gestation:  | Estimated Due Date: |
| **INFANT’S NAME & DATE OF BIRTH** |
| Name: | Date of birth: Age in months: |
| **ADDITIONAL CHILDREN IN THE HOUSEHOLD** |
| YesNo If yes complete the child/ren’s details below. |
| **Child’s name:** | **Childs age:** |
| **Child’s name:** | **Child’s age:** |
| **Child’s name:** | **Child’s age:** |
| **Please provide details of any additional people in the household?** |

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| **SECTION 2 - REFERRAL CONSENT** |
|  | If no, please give a reason why: |
| Does the parent/carer consent to the referral?  | Yes | No |  |
| Hampshire and Isle of Wight ICB commission a number of organisations to support and treat adult and children’s mental health and well-being. To ensure that your referral reaches the right service to meet your needs, we may need to share your information with other organisations, which could be the Isle of Wight NHS Trust, Youth Trust or Barnardo’s depending on age. *If you* ***Do*** *want us to share your information, please tick here.* | Yes | No |  |

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| **SECTION 4 – REFERRER DETAILS** |
| Name: | Job Title/Profession: |
| Organisation: | Email address: |
| Contact number: | [Barnardo’s staff – Content Server link to family file] |
| Date of referral: |
| **SECTION 5 – MIDWIFE DETAILS** | **SECTION 6 – HEALTH VISITOR DETAILS** |
| Name: | Name: |
| Email: | Email: |
| Contact number: | Contact number: |

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| **SECTION 6 – INFANT DETAILS** |
| Subject to Child Protection PlanCurrentHistoricalNone | Subject to Child in Need Plan-CurrentHistoricalNone | Subject to a CAF/TAF-CurrentHistoricalNone | Other-Please provide details… |
| Does the infant have a disability/condition or any specific needs?Yes No If yes, please provide additional information about the type of condition/disability: - |
| **SECTION 6 – MENTAL HEALTH CONCERNS; Please summarise the reasons for the referral:** |
| Reasons for referral/presenting concerns:*Please describe the current nature of difficulties, such as presentation, onset, frequency, and duration.*  |
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| What impact is this having on the parent/infant and those around them?*Consider impact on relationship / health / sleep / persona / motivation / engagement / enjoyment of activities.*  |
| What services or interventions have been accessed by the parent/carer in relation to the current concerns? *When were they accessed? For how long? Were they successful?* |
| What additional services have the parent/s accessed in regard to other children in their family e.g. *Family Links Nurturing Programmes (if applicable).* |
| Presenting risk to self:*Please give details regarding the parent/carer’s risk to themselves e.g.,* *Self-harm, Suicidal thoughts or actions, risk to others, risk from others.*  |
| What does the parent hope that PAIR TEAM can do for them?*Which concerns are impacting them the most? What would they like to be different? How would this look for them?*  |
| Please describe a brief history of the PARENT/CARER/INFANT, *you may wish to provide information about the birth?* |
| **Preferred Method of Contact** *(Tick all that apply)* | Home phone | Mobile | Text | Letter | Email | Other |
| **Can parent/carer travel?** | Yes | No |

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| **Parent-infant relationship risk factors**  |
| Parent factors  | Caregiver 1 | Caregiver 2 |
|  | Please tick |
| History/ current anxiety or depression |  |  |
| History / current alcohol and / or drug misuse |  |  |
| Serious medical condition |  |  |
| Learning Disability  |  |  |
| Neurodivergence |  |  |
| Single teenage parent without family support |  |  |
| Past criminal or young offenders record |  |  |
| Previous child has been in foster care or adopted |  |  |
| Violence reported in the family |  |  |
| Acute family crisis or recent significant life stress |  |  |
| Ongoing lack of support / isolation |  |  |
| Inadequate income / housing |  |  |
| Previous child has behaviour problems |  |  |
| Parent has experienced loss of a child |  |  |
| Background of abuse, neglect, loss in childhood or episodes of being in care as a child |  |  |
| Chronic maternal stress during pregnancy or ambivalence about the pregnancy (unplanned or rigorous planning) |  |  |
| Disappointment or unrealistic expectation around the parent-infant relationship |  |  |
| Other: please describe |  |  |
| Factors observed in parent-infant relationship  | Caregiver 1 | Caregiver 2 |
| Lack of sensitivity to baby’s cries or signals |  |  |
| Negative feelings towards baby |  |  |
| Physically punitive / rough towards baby |  |  |
| Lack of vocalisation to baby |  |  |
| Lack of eye-to-eye contact |  |  |
| Infant has poor physical care (e.g. dirty or unkempt) |  |  |
| Does not anticipate or encourage child’s development |  |  |
| Lack of consistency in caregiving  |  |  |
| Infant factors  |  |
| Developmental delays |  |
| Exposure to harmful substances in utero  |  |
| Traumatic birth |  |
| Congenital abnormalities / illness |  |
| Very difficult temperament / extreme crying / hard to soothe |  |
| Very lethargic / nonresponsive / unusually passive |  |
| Low birth weight / prematurity |  |
| Resists holding / hypersensitive to touch |  |
| Severe sleep difficulties |  |
| Failure to thrive / feeding difficulties / malnutrition  |  |

**Please note- all completed referrals must be sent by email and encrypted from outside Barnardo’s.**

**The PAIR TEAM are unable to assist parent/carers with severe, complex, or enduring mental health difficulties, or those at high risk, requiring specialist levels of care.**

**The PAIR TEAM service is *not* a crisis service therefore if you feel a parent/carer/infant is at risk and needs urgent mental health support then please contact:**

**NHS 111**

**Or text ‘SHOUT’ to 85258 for free, anonymous, confidential support**

 

   

Send referral by email: iowfamilycentres@barnardos.org.uk

Barnardo’s Isle of Wight