



**REFERRAL FORM: Parent and Infant Relationship Service (PAIRS)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual** | **Forename** | **Surname** | **DoB / EDD** | **NHS No** |
| **Mother’s Name** |  |  |  |  |
| **Identified Infant** |  |  |  |  |
| **Sibling’s Name** |  |  |  |  |
| **Sibling’s Name** |  |  |  |  |
| **Sibling’s Name** |  |  |  |  |
| **Sibling’s Name** |  |  |  |  |
| **Father/Partner** |  |  |  |  |
| **Other Adult** |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY’S CONTACT DETAILS** | | | |
| **Address** |  | | |
| **Post code** |  | **Mobile** |  |
| **Spoken Language** |  | **Telephone** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***KEY PROFESSIONALS INVOLVED***  *if you are the referrer you Do Not Need to Duplicate Your Details – Please Simply Insert Your Name* | | | |
| **Named GP and Surgery** |  | | |
| **Referrer Name and address** |  | | |
| **Referrer Telephone** |  | **Referrer Email** |  |
| **Social Worker Name & Team** |  | | |
| **SW Telephone** |  | **SW Email** |  |
| **Health Visitor Name** |  | **Health Visitor Team** |  |
| **Health Visitor Telephone** |  | **Health Visitor Email** |  |
| **Midwife Name** |  | **Midwife Team/Hospital** |  |
| **Midwife Telephone** |  | **Midwife Email** |  |
| **Adult Mental Health Team** |  | **Adult MH Contact** |  |
| **Adult Mental Health Tel** |  | **Adult MH Email** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **OTHER PROFESSIONALS INVOLVED IN THIS FAMILY**  If You Need to Add More Professionals (i.e. Schools, Nursery etc) Use a Separate Sheet | | | |
| **Name** | **Role** | **Team** | **Telephone/Email** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Your reasons for making this referral**  Why do you think that this parent and infant may need the support of our service? It can be helpful to do this with the parent and to use some of their own words. |
| ***Additional Concerns/helpful information about the family including any disabilities?***  ***elpful information about the family*** |

|  |
| --- |
| **Date of Referral: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_** |

***Many thanks - we will get back to you as soon as is possible to discuss your referral.***

**Please return this form to us via email:** pairs\_lambeth@slam.nhs.uk

**Alternatively, you can post to us at:** Parent and Infant Relationship Service, 5th Floor Civic Centre, 6 Brixton Hill, London, SW2 1EG Tel: 02032286771

|  |
| --- |
| ***(Office use only)***  ***Date Referral received: Leap Ward: Yes / No (please delete as appropriate)*** |