

**TOGETHER TIME REFERRAL FORM:**

**Parent and Infant Relationship Service (PAIRS)**

**Please send the referral form to:** [pairs\_lambeth@slam.nhs.uk](mailto:pairs_lambeth@slam.nhs.uk)

|  |  |  |
| --- | --- | --- |
| Parent’s name: | Infant’s name: | Age: |
| Parent’s Contact details:  Address: | Phone: | |
| Does the family live in the LEAP area? Y/N | | |
| Referrer details:  Name:  Contact details: | | |
| Reasons for referral: | | |
| Additional information (inc. any risk/safeguarding concerns) | | |

Group Criteria:

Age: The group is for parents with a baby aged between 3 and 8 months old