

**TOGETHER TIME REFERRAL FORM:**

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

**Please send the referral form to:** pairs\_lambeth@slam.nhs.uk

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| --- | --- | --- |
| 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