Healthy Little Minds

SSBC small steps big changes City Care

Nottingham City Council

For HLM Office Use	
Date Received	
Support call	
Outcome	

Self-Referral Form

Healthy Little Minds provides support focusing on the very special relationship between parents and infants that develops during the first 1001 days of life. We recognise being a parent is a source of happiness and joy. However, it can also be unexpectedly difficult for a variety of reasons. Please us this form to tell us about what you are finding difficult and we will contact you by telephone to discuss your referral further.

Healthy Little Minds support babies and infants (from 20 weeks of pregnancy to 2yrs of age), and their parents/carers/families who live in Nottingham City.

Family Details

Baby's Details

Name:	
Date of Birth / Due Date:	NHS Number (if known):
Address line 1: Address line 2:	Post Code:
Gender: MALE ☐ FEMALE ☐	Ethnicity:
Who has parental responsibilty?	

Parent / Caregiver 1 Details

Name:	Date of Birth:
NHS Number (if known):	Tel No:
Address line 1: Address line 2:	Post Code:
Ethnicity:	Main language spoken at home:
Is an interpreter needed? YES ☐ NO ☐	If so which language?
Are there any specific requirements/support needs you would like to tell us about? YES ☐ NO ☐ If 'yes' please give details:	

Parent / Caregiver 2 Details

Name:	Date of Birth:
NHS Number (if known):	Tel No:
Address line 1: Address line 2: Post Code:	
Ethnicity:	Main language spoken at home:
Is an interpreter needed? YES ☐ NO ☐	If so which language?
Are there any specific requirements/support needs you would like to tell us about? YES ☐ NO ☐ If 'yes' please give details:	

Other's Details

Are there other children living in the house? YES ☐ NO ☐ If 'yes' please provide names and dates of birth:
Please tell us about any other important adults in baby's life:

Please tell us about any other professionals who are working with your family

GP	Name:
Address:	Contact:
Midwife / Health Visitor	Name:
Address:	Contact:
Key Worker	Name:
Address:	Contact:
Adult Mental Health Services	Name:
Address:	Contact:
Paediatrician	Name:
Address:	Contact:
Social Worker	Name:
Address:	Contact:
Targeted Family Support Worker	Name:
Address:	Contact:
Children's Centre	Name:
Address:	Contact:

Any other professional?	Name:
Address:	Contact:
Any other professional?	Name:
Address:	Contact:

Are there any current or previous concerns about your child/children's safety or well-being? YES ☐ NO ☐

If 'yes', please tick:	☐ Child protection	☐ Looked After Child	☐ Child in Need

Please give details:

The involvement of Children's Social Care will not affect Healthy Little Minds working with you

Reason for referral

Please use the box below to tell us in your own words more about your worries, the support you need and how you would like your relationship with your baby to be different.

It can sometimes be hard to put our worries into words, if it helps to use the tick boxes on the next page then please do so.

Please let us know if you are experiencing any of these difficulties:	Caregiver 1 NAME:	Caregiver 2 NAME:
Anxiety or depression (now or in the past)	☐	☐
Alcohol and / or drug misuse (now or in the past)	☐	☐
Serious health condition	☐	☐
Learning Disability	☐	☐
Single teenage parent without any family support	☐	☐
Criminal record or in trouble with the Police	☐	☐
Previous child has been in foster care or adopted	☐	☐
Violence in the family	☐	☐
Family crisis or very stressful life event(s)	☐	☐
Lack of support / feeling isolated	☐	☐
Low income / housing issues	☐	☐
Previous child has behaviour problems	☐	☐
Parent has experienced loss of a child	☐	☐
Parent experienced episodes of being in care as a child	☐	☐
Experience of abuse, neglect or loss (now or in the past)	☐	☐
High levels of stress during pregnancy or mixed feelings about the pregnancy	☐	☐
Disappointment around the parent-infant relationship	☐	☐
Unplanned pregnancy	☐	☐
Other: please describe below	☐	☐
Please let us know if you are struggling with any of the following:		
Responding to baby's cries or signals	☐	☐
Feelings towards baby	☐	☐
Fearing rough handling of baby	☐	☐
Talking and playing with baby	☐	☐
Finding eye contact difficult	☐	☐
Caring for baby's physical needs – keeping them clean, safe and fed	☐	☐
Do not know how to encourage baby's development	☐	☐
Lack of confidence in handling baby	☐	☐

Has baby experienced any of the following	
Developmental problems / delay	YES ☐ NO ☐
Exposure to drugs / alcohol or other risks during pregnancy	YES ☐ NO ☐
Traumatic or upsetting birth	YES ☐ NO ☐
Any illness or concerns at birth	YES ☐ NO ☐
Very difficult to comfort and soothe	YES ☐ NO ☐
Seems uninterested / quiet /doesn't respond as you'd expect	YES ☐ NO ☐
Low birth weight / premature birth	YES ☐ NO ☐
Doesn't like being held	YES ☐ NO ☐
Severe sleep difficulties	YES ☐ NO ☐
Feeding difficulties / growth	YES ☐ NO ☐

Parental consent

I confirm I consent to the referral to Healthy Little Minds

Name:	Date:

We will contact you by telephone to let you know we have received your referral and to provide you with the opportunity to provide more details. Thank you.

Send your form to CYPBEHM@nottinghamcity.gov.uk