Healthy Little Minds

SSBC small steps big changes CityCare

Nottingham City Council

For HLM Office Use	
Date Received	
Support call	
Outcome	

Referral Form

Referrer Details

Name:	
Your organisation and position:	
Tel No:	Email:
Address:	
Is this a request for: DIRECT SUPPORT ☐ or PROFESSIONAL CONSULTATION ☐	
Has the referral been discussed with the family? YES ☐ NO ☐ If 'no' why not?	
Have the family consented to the referral? YES ☐ NO ☐ *Please note we will not accept referrals where consent has not been sought.*	

Guidance for Referrers

Healthy Little Minds aims to support the relationship between the parent and their infant when there is a risk to this relationship.

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

Please ensure these criteria are met before submitting your referral.

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?
Disability/additional needs? 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?
Disability/additional needs? 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 provide details of any other significant or supportive adults:

Professional involvement

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:

Are there any safeguarding concerns? YES ☐ NO ☐ If 'yes', please tick below

☐ Child protection ☐ Looked After Child ☐ Child in Need ☐ Early Help

Please give details:

State any issues that may affect home visiting (e.g. no lone visiting):

Reason for referral

Healthy Little Minds aims to support parent-infant relationships. Please use the box below to explain your reason for referring the family, including a brief description of concerns and any observations of the parent-infant relationship.

A list of risk factors for parent-infant relationship difficulties is also included here (table goes over page). Please use this list to consider if Healthy Little Minds is the appropriate service for this family and tick the factors that apply.	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	☐	☐
Factors observed in parent-infant relationship		
Lack of sensitivity to baby's cries or signals	☐	☐
Negative / ambivalent / indifferent 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	YES ☐ NO ☐
Exposure to harmful substances in utero	YES ☐ NO ☐
Traumatic birth	YES ☐ NO ☐
Congenital abnormalities / illness	YES ☐ NO ☐
Very difficult temperament / extreme crying / hard to soothe	YES ☐ NO ☐
Very lethargic / nonresponsive / unusually passive	YES ☐ NO ☐
Low birth weight / prematurity	YES ☐ NO ☐
Resists holding / hypersensitive to touch	YES ☐ NO ☐
Severe sleep difficulties	YES ☐ NO ☐
Failure to thrive / feeding difficulties / malnutrition	YES ☐ NO ☐

Please tell us about any Protective Factors:

What are the families wishes and feelings regarding the referral?

What would you hope to be the outcome of this referral?

Please include as much information as possible to ensure we are able to best respond to the request of support. Healthy Little Minds will confirm receipt of the form.

Send your form to CYPBEHM@nottinghamcity.gov.uk