CONTACT REFERRAL FORM

REFERRER DETAILS	
Name of person making the Referral	
Relationship to Child/Children	
Address	
Email	
Contact Number	
Email for contact report to be sent	
Email recipient name	
Email for Invoicing	
Address for Invoicing	

TYPE OF CONTACT REQUIRED	
Please indicate which of the following service you required: Supervised contact – Supervised at all times. Written report of contact. Supported Contact – Facilitated no report. Hospital Contact – Supervised at all times. Written report of contact. Contact Handover – Centre or agreed community based drop off and pick up point.	
Centre based Supervised Contact – Weekday	
Centre based Supervised Contact Weekend	
Supervised Contact Community	
Supported Contact – Centre based only	
Hospital Handover	
Contact Handovers	

CONTACT REQUIRED	
Frequency of contact required	
Is frequency specified in a court order	
If specified in court order, was this agreed by all parties	
Duration of contact	
Start date	
End date	

COURT ORDERS
Type of order (Residence, contact, parental responsibility, injunctions) **Please specify and provide a copy along with your referral form.**

NAME OF KEY PROFESSIONALS WORKING WITH YOU		
Social Worker	**Name**	
	Contact Number	
	Email	
CAFCASS	**Name**	
	Contact Number	
	Email	
Solicitor	**Name**	
	Contact Number	
	Email	
Probation Officer	**Name**	
	Contact Centre	

	Email	
Other		
Do you give permission for us to contact them? **This forms part of our pre-checks prior to accepting referral**		**YES / NO**

CHILD/CHILDREN				
Name(s)	**Age**	**Date of Birth**	**Gender**	**Ethnicity**
Who has parental responsibility?				

ADULT WITH WHOM THE CHILD/CHILDREN LIVES WITH	
Name	
Relationship to Child/Children	
Ethnicity	
Address	
Postcode	
Contact Number	
E mail	

PERSON HAVING CONTACT	
Name of person having contact	
Relationship to Child/Children	
Address	
Contact Number	

Who will be responsible for bringing and collecting child(ren) from contact? **Details:**	
Are any other adults or children allowed to participate in the contact sessions?	**YES / NO**
Name of adults	
Relationship	
Name of child(ren)	
Relationship	
Are there any risk issues if the separated parents (or other adults) meet at the contact centre?	**YES / NO**
If yes, please specify the risk issues below:	

HEALTH AND MEDICAL REQUIREMENTS	
Do any of the children or adults attending contact have any special needs or requirements relating to illness, impairment, allergies, and special needs or other? **(Please specify)**	
Children	
Adults	
If on medication, will any medication need to be taken during contact?	**YES / NO**
Please note if you answered "yes" to the above question, you will need to complete our medication form. Staff will not be able to administer	

medication and this will be the responsibility of the parent/carer having supervised contact

LANGUAGE/INTERPRETER REQUIREMENTS	
Will an interpreter be required?	**YES / NO**
Language spoken:	
If yes, will you arrange an Interpreter?	**YES / NO**
Would you like us to arrange an interpreter? (payment will be included in overall cost of contact)	**YES / NO**

RISKS OR CONCERNS
Are there any concerns or risks that we should be aware of? If yes, please provide details in the space provided below.

CONTACT REQUIREMENTS
Are there any specific requirements for contact that we need to be aware of to make the contact enjoyable for the child/children?
E.g. - dietary needs, activities, toiletry needs etc…

Please email completed form to:
referrals@thebrightconnections.com

Name	
Signature	
Relationship to child/children	
Date	