Believe in children
Barnardo's Northern Ireland

Incredible Years Parenting Programme - Referral Form

Please note that all referrals must be made with the consent of the family

Date: _____

Name of parent/carer: _____

Address: _____

_____

Tel. No.: _____

Name of Child / Children
(if more than 1 child in one family): DOB school attending/year

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

Programme requested/ reasons for referral:

_____

_____

_____

_____

What does the family hope to gain from this programme? _____

_____

_____

Is the family using any other service? **(eg. Speech Therapist, Social Services, EWO)**

_____

Parent willingness to participate in programme _____

(Signature of parental consent)

Details of referrer:

Name:_____ Self/ Professional

Address: _____

Telephone number_____

Please return this form to

East Belfast Family Connections, Kings Road, Belfast, BT5 7EH