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:	Postcode:
Tel. No:	

Name of Child/Children referral relates to:		DOB:	Age:	School attending/year:
1.				
2.				
Other Child/Children in family:		DOB:	Age:	School attending/year:
3.				
4.				

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:

Gemma Lutton, CYPSP, Health & Wellbeing Team, Braid Valley Hospital Site, Cushendall Road, Ballymena, BT43 6HL

For queries contact: 028 2563 6615 **Email:** gemma.lutton@northerntrust.hscni.net