

**Families First**

**TÎM CAMAU BACH**

**Referral Form**



**Before making a referral to the Disability Referral Triage, please consider the following definition of a Disability under Families First guidance:**

Within the Families First Programme we are using the United Nations Convention on the Rights of Persons with Disability (2009) which defines persons with disabilities as:  ***“…those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”***



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**Child/Young Person’s Details**

|  |  |
| --- | --- |
| **Date of Referral** |  |
| **Name of Child/Young Person** |  | **Date of Birth/EDD:** |  |
| **Main address including post code** |  |
| **Home Number** |  |
| **Mobile Number** |  |
| **Email** |  |
| **Do you have transport?** |  |
| **Parents/Carers** | **Name** | **Relationship** | **DOB** | **Employment Status** |
|  |  |  |  |  |
| **Siblings**  | **Name** | **DOB** | **School** |
|  |  |  |  |

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| --- |
| **Other Professionals** |
| **GP / Surgery** |  |
| **Midwife**  |  |
| **Health Visitor** |  |
| **School Health Nurse** |  |
| **Social Worker** |  |
| **Childcare / School** |  |
| **Others (please state)** |  |

**Person Referring**

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Contact phone no** |  |
| **Email address** |  |
| **Job Title / Role** |  |
| **Agency** |  |

|  |  |
| --- | --- |
| **Known Disability****If yes, please state known condition:** | **YES / NO** **DIAGNOSED / UNDIAGNOSED** |
| **What are the main impacts of the disability?** **e.g sleep, sensory issues, behaviour, continence, etc.** |  |
| **What previous support has been received?****e.g. Flying Start / SALT / OT** |  |
| **What specific support would be of benefit?** | Home BasedPre-SchoolContinence / Sleep ClinicChild Support Group Parenting Support GroupOther: (Please specify) |
| **What would be the desired outcome following support?** |  |

**Has a JAFF already been completed? YES / NO**

If they answer is yes, please ensure this is sent with the referral.

**Please email this referral form or send to:**

**DisabilityReferrals@carmarthenshire.gov.uk**

**Or**

**Kelly Witts**

**Family Support Coordinator**

**Tîm Camau Bach**

**St Anne’s Building**

**Parc Dewi Sant**

**Jobs Well Road**

**Carmarthen**

**SA31 3HB**



**Teuluoedd Yn Gyntaf**

**TÎM CAMAU BACH**

**Ffurflen Atgyfeirio**



**Cyn gwneud atgyfeiriad i'r broses Brysbennu ar gyfer Atgyfeiriad Anabledd, ystyriwch y diffiniad canlynol o'r term Anabledd yn ôl canllawiau Teuluoedd yn Gyntaf:**

Yn y Rhaglen Teuluoedd yn Gyntaf rydym yn defnyddio Confensiwn y Cenhedloedd Unedig ar Hawliau Pobl ag Anableddau (2009) sy’n rhoi’r diffiniad hwn o bobl ag anableddau:  ***“…rhai sydd â namau ar y synhwyrau neu namau corfforol, meddyliol neu ddeallusol hirdymor a allai, wrth ryngweithio ag amryw rwystrau, eu llesteirio rhag cyfranogi’n llawn ac effeithiol mewn cymdeithas yn gyfartal ag eraill”***



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**Manylion y Plentyn/Person Ifanc**

|  |  |
| --- | --- |
| **Dyddiad yr atgyfeiriad** |  |
| **Enw'r plentyn / person ifanc** |  | **Dyddiad Geni /Dyddiad Geni Disgwyliedig:** |  |
| **Prif gyfeiriad gan gynnwys côd post** |  |
| **Rhif ffôn y cartref** |  |
| **Rhif ffôn symudol** |  |
| **E-bost** |  |
| **A oes trafnidiaeth gennych?**  |  |
| **Rhieni / gofalwyr** | **Enw** | **Perthynas** | **Dyddiad geni** | **Statws cyflogedig** |
|  |  |  |  |  |
| **Brodyr a chwiorydd**  | **Enw** | **Dyddiad geni** | **Ysgol** |
|  |  |  |  |

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| --- |
| **Gweithwyr Proffesiynol Eraill** |
| **Meddyg / Meddygfa** |  |
| **Bydwraig**  |  |
| **Ymwelydd Iechyd** |  |
| **Nyrs Iechyd yr Ysgol** |  |
| **Gweithiwr Cymdeithasol** |  |
| **Lleoliad Gofal Plant/Ysgol** |  |
| **Eraill (nodwch)** |  |

**Y sawl sy'n atgyfeirio**

|  |  |
| --- | --- |
| **Enw** |  |
| **Cyfeiriad** |  |
| **Rhif ffôn cyswllt** |  |
| **Cyfeiriad e-bost** |  |
| **Teitl/rôl y swydd** |  |
| **Asiantaeth** |  |

|  |  |
| --- | --- |
| **Anabledd Hysbys****Os felly, nodwch y cyflwr hysbys:** | **Oes / Nac Oes** **WEDI CAEL DIAGNOSIS / HEB GAEL DIAGNOSIS** |
| **Beth yw prif effeithiau'r anabledd?** **e.e. cwsg, problemau synhwyraidd, ymddygiad, ymataliaeth, ac ati** |  |
| **Pa gymorth a gafwyd yn y gorffennol?****e.e. Dechrau'n Deg / Therapydd Iaith a Lleferydd / Therapi Galwedigaethol** |  |
| **Pa gymorth penodol fyddai'n fuddiol?** | Cymorth yn y cartrefCymorth cyn-ysgolClinig cysgu / ymataliaethGrŵp Cynnal Plant Grŵp Cymorth RhiantaArall: (Rhowch fanylion) |
| **Beth fyddai’r canlyniadau a ddymunir o ganlyniad i gael cymorth?** |  |

**A oes Fframwaith Asesu'r Teulu ar y Cyd eisoes wedi cael ei gwblhau? Oes / Nac Oes**

Os oes, sicrhewch ei fod yn cael ei anfon ynghyd â'r atgyfeiriad.

**Anfonwch y ffurflen atgyfeirio hon at:**

**DisabilityReferrals@sirgar.gov.uk**

**Neu at**

**Kelly Witts**

**Cydgysylltydd Cymorth i Deuluoedd**

**Tîm Camau Bach**

**Adeilad y Santes Ann**

**Parc Dewi Sant**

**Heol Ffynnon Job**

**Caerfyrddin**

**SA31 3HB**