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| **ROSCREA YOUTH SERVICE ONE TO ONE COUNSELLING REFERRAL FORM****PROFESSIONAL ONE TO ONE COUNSELLING** **WELL-BEING AND MENTAL HEALTH** |
| Please fill in whatever details you may have on this referral form |

**Consent for under 18’s is required**

**Age remit to avail of service is 10-17years**

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| **(1) Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Referred By:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Tel:/E-Mail****:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Is Parent(s) aware of referral? Yes  No **

**Is the young person aware of the referral? Yes  No **

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| **(2) Details of Referral:** |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Family Details:** | **Age:** **(if known)** | **Phone No:** | **Next of Kin****(under 18s)** | **Emergency Contact** |
| **Mother** |  |  |  |  |
| **Father** |  |  |  |  |
| **Carer** |  |  |  |  |
| **Brothers/Sisters** |  |  |  |  |
| **Other Significant** |  |  |  |  |

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| **(3) Details of Agency/Personnel involved with young person of family (if any)** |

**Social Worker:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_**

**CAMHS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GP/Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Garda: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Station: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Drugs/Alcohol Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Support Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has this family/young person recently been referred to another service (Please give details)**

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**Consent for under 18’s is required**

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| **(4) Reason for Referral of Young Person** |
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| **(5) Expectations of:** |
| **Referrer:** |
|  |
|  |
|  |
| **Young Person:** |
|  |
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| **Family: Parent/Carer** |
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| **(6) Please detail any other background information relating to the child/young person or family which may be relevant (this could include matters relating to childcare, family relationships, health, ability/disability, race, religion, culture, language/communication, education, other)** |
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**Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Referrer)**

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send completed forms:**

By Post: F.A.O. Kate Flynn

North Tipperary Development Company,

Family Support Worker

Roscrea Youth Service, Rosemary Street, Roscrea

By E-Mail:

Kflynn@ntdc.ie

Telephone Enquiries: 087 - 9529041