Roscrea Youth Service

Family Support Referral Form

Please return to:

Family Support Worker, Roscrea Youth Service, Rosemary Street, Roscrea, E53 C859

*Please fill in whatever details you may have on this referral form. Data is stored & used as per NTDC Data Protection Policy.*

**Referral details:**

|  |  |
| --- | --- |
| **For the Referrer** | *For office use only* |
| **Date of Referral:**  | **Referred by:** | **Contact details:** | *Received on:* | *Referral suitable for our service?* |
|  |  |  |  |  |

**Young person’s/ Family details:**

|  |  |
| --- | --- |
| **Name of young person/family referred:**  |  |
| **Also known as:** |  |
| **Date of birth:** |  | **Age:** |  |
| **Gender:** | F M (please tick as appropriate) |
| *\*Please see Appendix 1**if there is a need for more than one child in the family to receive support.* *\*\*If you are referring the whole family/parent, write the name of the family/parent in this section.*  |

##

## Family/Household Composition:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of birth** | **Gender** | **Role within family** | **School/Occupation** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**\**Please add more rows as required***

## Parents or guardians:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Phone Number** | **Address** | **Legal responsibility** | **First language** | **Interpreter required?** |
| **Mother** |  |  |  |  |  |
| **Father** |  |  |  |  |  |
| **Guardian** |  |  |  |  |  |

## Please identify the main reasons for the referral:

* Tick as appropriate

|  |  |  |  |
| --- | --- | --- | --- |
| Emotional issue |  | Behavioural issue |  |
| Physical illness / disability |  | Mental health issue |  |
| Learning disability  |  | Substance misuse / Addiction |  |
| Educational issue (for example school attendance) |  | Family issues (for example bereavement) |  |
| Social isolation |  | Parenting support |  |
| Financial/ housing difficulties |  | Relationship issues |  |
| History of domestic violence |  | Other (please specify): |  |

## Please include any additional information to support the referral:

## Agencies working with the family:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name of family member** | **Name of key contact in agency** | **Phone number/ Other relevant info** |
| **Mental Health (Adult services/CAMHS)** |  |  |  |
| **Crèche/Childcare** |  |  |  |
| **PHN** |  |  |  |
| **School/Training Centre** |  |  |  |
| **GP** |  |  |  |
| **Drugs/Alcohol service** |  |  |  |
| **Disability service** |  |  |  |
| **Educational welfare service** |  |  |  |
| **OT/S&L/Physio** |  |  |  |
| **JLO/Gardaí/Probation** |  |  |  |
| **NEPS** |  |  |  |
| **Social Work: Medical/Primary Care/Mental Health** |  |  |  |
| **Social Work:****Tusla (Child protection & welfare)**  |  |  |  |
| **Youth Service/ Sports/Clubs** |  |  |  |
| **Other** |  |  |  |

**Referrer’s Details:**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

## Consent to information sharing and storage:

* ***I agree and understand the information recorded on this form.***
* ***I agree that this information can be stored and used to provide services to myself and the child(ren) for whom I am the parent/carer and to the actions identified on this form.***
* ***I agree that this information may be shared with other professionals to ensure that there is no duplication of service.***
* ***I agree that my case may be assessed as appropriate for Meitheal and that the next possible stage may be to engage in the Meitheal process.***
* ***I agree that my child(ren) has the option of participating in this process.***
* ***I agree that this information may be shared on a need-to-know basis with key or appropriate staff within these agencies for the above purposes only.***
* ***I understand that if a concern arises about my child(ren) being subject to abuse or neglect that a referral must be made to the Child and Family Social Work Service in line with the requirements of Children First Legislation and Guidance.***

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Young Person Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referrer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Appendix 1**

**Additional young person:**

Please complete one of these tables per additional child/ young person engaging in family support.

|  |  |
| --- | --- |
| **Name of young person/family referred:**  |  |
| **Also known as:** |  |
| **Date of birth:** |  | **Age:** |  |
| **Gender:** | F M (please tick as appropriate) |

|  |  |
| --- | --- |
| **Name of young person/family referred:**  |  |
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