

Medical Cont'd

2. Is the young person on medication?

Yes ☐ No ☐

If yes, please list the medication, dosage and when started.

3. Does the young person have any physical health limitations or needs that might be of concern in a training environment, that can be physically demanding?

Yes ☐ No ☐

If yes, please explain.

Contact One

Name: _____ Relationship: _____

Telephone Number: _____ Mobile Number: _____

Address: _____

Contact Two

Name: _____ Relationship: _____

Telephone Number: _____ Mobile Number: _____

Address: _____

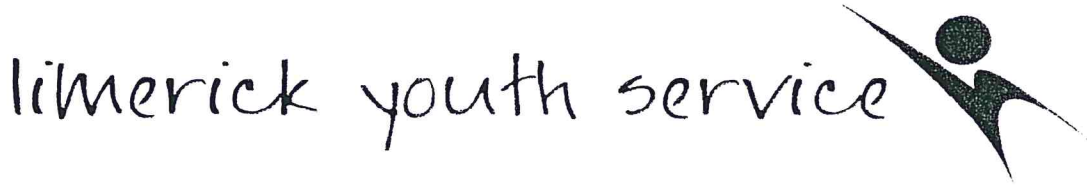
Contact Three

Name: _____ Relationship: _____

Telephone Number: _____ Mobile Number: _____

Address: _____

Please provide any additional comments/observations, which you feel may be relevant to making an Assessment of whether this Programme is appropriate for this young person's needs. (Use additional sheets if necessary or attach the information).



Community Training Centre
Referral Form

Self-Referral	<input type="checkbox"/>
Parent/Guardian	<input type="checkbox"/>
Agency	<input type="checkbox"/>

Referral Date: _____

Personal Details

Learner's Name: _____

Address: _____

Telephone Number: _____ Date of Birth: _____

PPS Number: _____ Welfare Payment Type: _____

Referral Agent Information

Referring Agency: _____

Lead Contact Name for Referral Information: _____

Position: _____

Lead Contact Email Address: _____

Telephone Number: _____

Postal Address: _____

Education

What is the highest educational level you have completed? (Please tick the relevant boxes).

- No Formal Education☐
- Primary School☐
- Junior Certificate (Four D's or Less)☐
- 5th Year☐
- Leaving Certificate (One to Four Subjects)☐
- Leaving Certificate (Five Subjects)☐
- Higher than Leaving Certificate☐

Are any of the following Agencies currently involved or have been involved with this young person?
(Please give details including Contact Names, Telephone Numbers and Dates involved).

Social Welfare	Schools	Community Welfare Officer
Mental Health Service	Juvenile Liaison Officer/Garda	Probation Service
Court/Legal Service	Addiction Service	Social Services
Family Mediation Service	Residential Facilities	Other Youth Projects
Child Guidance		

What is the primary reason for referring this young person to Limerick Youth Service?

Please describe any recent behaviour concerns regarding this young person?

Does this young person have any psychological disorders? (Explain).

Please describe the extent to this young person's use of drugs/alcohol/tobacco (amount and frequency of use, impact on young person's behaviour).

Has this young person experienced any traumatic events or major changes in his/her life that are believed to be relevant to his/her current behaviour or this referral?

Has this young person been in Counselling or the subject of any Professional Assessment in the past two years?

Yes☐No☐

If yes, please list and advise if these are available for review.

Medical

1. Does the young person have any allergies?

Yes☐No☐

If yes, please describe reaction.