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).

_____

_____

limerick youth service

Community Training Centre

Referral Form

Self-Referral	☐
Parent/Guardian	☐
Agency	☐

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.

   _____
   _____