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**Individual Data Consent Form**

**For Parent/Guardian Referrals (Under 18s)**

The Be Well Team: Youth Mental Health Service records information on the young people that we work with. We require personal information including name and contact details, age, gender, nationality, educational and employment status and medical information. This is necessary for contact, health and safety reasons, reporting to our funders and to ensure relevant supports with the best possible results. We would also like to record information on any **additional physical, mental or learning support needs** and on **ethnic/cultural background.** This information is known as ‘Sensitive Data’, which is voluntary, and so does not have to be provided. We gather this information so as to ensure that LYS provides an equal, inclusive and diverse youth mental health service. We collect this information on a *‘Referral Form’* and *‘Therapy Assessment Form’*, which is then stored securely on paper format and on a computer data base for 7 years from when the young person leaves LYS.

The young person may have additional support needs, which could benefit from more specific supports and/or referrals to organisations and agencies outside of LYS. In these instances and **ONLY** with parent/guardian prior consent, the relevant information may be shared with these agencies. Please be aware that under the Children's First Act 2015, we are obliged to report any concerns regarding child safeguarding to the relevant authority. Under the Irish Data Protection Acts and the EU General Data Protection Legislation (GDPR), 2016, you have a right to request a copy under/over 18s personal information at any time. Your consent to provide any of the information required by LYS can be withdrawn at any time, or to have the young person’s file deleted. This can be done by contacting Sinead Noonan at 061 412444 or sineadn@limerickyouthservice.org.

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| **Data Consent** | **Signature (Please X if submitting online, or provide signature if submitting in paper format)** |
| I give consent to record sensitive information relating to additional physical, mental or learning support needs and ethnic/cultural background |  |

PRINT UNDER YOUNG PERSONS NAME:

PARENT/GUARDIAN SIGNATURE:

**DATE:**

**Limerick Youth Service – Be Well Team Parent/Guardian Referral Form**

(Please fill in referral form and return; if assessment appointment not attended, this document will be shredded.)\*

Consent for under 18’s is required (Age remit for team is age 14-25)

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

**Preferred mode of contact:** Call Email SMS

Viber

Whatsapp

**1. Family Contact Details:**

**Parent/Guardian Details 1:** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Parent/Guardian Details 2:** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Emergency Contact Details if different from above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**2. Young Person’s Details**

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

**Date of Birth:**  / / /

**Gender**: Male 🞎 Female 🞎 Other 🞎 Prefer not to say 🞎

**Nationality:** Irish 🞎 Other 🞎

**If other, please state:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is the young person is attending 2nd level?** YES 🞎 NO 🞎

**If yes, please provide a school name and brief address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the young person currently:** Employed🞎 Unemployed 🞎 In further education/training? 🞎

**3. Details on additional agency/personnel Involved, if any, with young person/family:**

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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication details (if any)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has young person/family recently been referred to another service**? YES 🞎 NO 🞎

**If yes, please give details:**

**Is referral currently on any waiting lists for other agencies?** YES 🞎 NO 🞎

**Please name the agency/ies­­­­­­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **4. Reason for referral of young person:** |
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| **5. Expectations of:** |
| **Young Person:** |
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| **Parent/Guardian:** |
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| **Any other information that may be of support to application ( For example additional physical, mental, learning support needs; ethnic/cultural background)** |
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**Signed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Parent/Guardian)**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\* **This form will be basis for discussion on assessment date**

All referral forms to be emailed to: [bewellteam@limerickyouthservice.org](mailto:bewellteam@limerickyouthservice.org) or posted to: Be Well Team, Limerick Youth Service, Northside Youth Space, Ballynanty Rd, Ballynanty, Limerick V94 TPP3

Any queries, please phone Siobhan O’Brien on 0863895031