****

**Individual Data Consent Form**

**Self-Referrals (Over 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 you leave LYS.

In cases where there exists additional support needs, more specific supports and/or referrals to organisations and agencies outside of LYS maybe beneficial. In these instances, and **ONLY** with your 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 of your 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 Your consent to provide any of the information required by LYS can be withdrawn at any time, or to have your file deleted. This can be done by contacting Sinead Noonan at 061 412444 or sineadn@limerickyouthservice.org.

|  |  |
| --- | --- |
| **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 NAME:

SIGNATURE:

DATE:

**Limerick Youth Service – Be Well Team Self- Referral Form (Over 18s)**

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

1. **Personal Details**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Date of Birth:**  / / /

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

**Nationality:** Irish 🞎 Other 🞎

**If other, please state:**

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

Viber

Whatsapp

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

**Are you currently attending 3rd level education?**  YES 🞎 No 🞎

**Are you currently:** Employed 🞎 Unemployed 🞎 In further education/training? 🞎

**If employed, are you in:** Full-time Employment 🞎 Part-time Employment 🞎

**2. Emergency Contact Details:**

**1:** **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**2: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**3. Details on additional agency/personnel involved, 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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Have you been 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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **4. Reason for self-referral:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| **5. Your Expectations:** |
|  |
|  |
|  |
|  |
|  |
|  |
| **Any other information that may be of support to application ( For example additional physical, mental, learning support needs; ethnic/cultural background):** |
|  |
|  |
|  |
|  |
|  |
|  |

**Signed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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