#  Limerick Youth Service – Be Well Team Agency Referral Form

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

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| **Is Parent(s) aware of referral?** |[ ]  Yes |[ ]  No |  |  |  |  |
| **Is the young person aware of the referral?** |[ ]  Yes |[ ]  No |  |  |  |  |
| **Preferred mode of contact for parent/guardian:** |[ ]  Call |[ ]  Email |[ ]  Whatsapp |[ ]  SMS |
| **Preferred mode of counselling for the young person:** |[ ]  Online |[ ]  Face to Face |  |  |  |  |

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| **Referrer Agency Details**  |
| **Referrer Name:** |  |
| **Referrer Agency:** |  |
| **Mobile Number:** |  |
| **Email Address:** |  |
| **Agency Address:** |  |

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| **Personal details of young person being referred** |
| **Name of Referral:** |  |
| **Date of Birth:** |  |
| **Mobile Number:** |  |
| **Email Address:** |  |
| **Address:** |  |

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| --- | --- | --- | --- | --- | --- |
| **Gender:**  |[ ]  Female  |[ ]  Male |  [ ]   | Other |[ ]  Prefer not to say  |
| **Nationality:** |[ ]  Irish |[ ]  Other |
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| **If other, please give details**  |
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**Is Young person being referred attending secondary school?** (Please check or tick appropriate box below)

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| --- | --- |
|[ ]  Yes  |[ ]  No |

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| **If yes, please provide a school name and brief address:**  |
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**Education & employment status** **of young person**

(Please tick **just one** of the boxes below and give additional details in the space provided below)

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|[ ]  Attending alternative secondary education, e.g. Youth Reach, Leaving Cert Applied (LCA)   |
|[ ]  In 3rd Level (degree or non-degree) e.g. Further Education Training, Apprenticeship   |
| [ ]   | Employed   |
| [ ]   | Unemployed   |
| [ ]   | Not in education, employment or training  |

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| **Please give additional details on above:**  |
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**Family Contact Details**

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| **Parent/Guardian Details 1:** |
| **Name:** |  |
| **Mobile No:** |  |
| **Email Address:** |  |
| **Address:** |  |

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| **Parent/Guardian Details 2:** |
| **Name:** |  |
| **Mobile No:** |  |
| **Email Address:** |  |
| **Address:** |  |

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| **Emergency Contact details if different from above:** |
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**Sensitive Personal Details of young person:**

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

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| --- | --- | --- | --- | --- | --- |
| Social Worker:    |   | Agency:    |   | Tel. No.    |   |
| CAMHS:    |   | Contact:  |   | Tel. No.    |   |
| AHMS: |  | Contact: |  | Tel. No. |  |
| GP / Doctor:    |   | Surgery:    |   | Tel. No.    |   |
| Garda:    |   | Station:    |   | Tel. No.    |   |
| Drugs/Alcohol Worker:  |   | Agency  |   | Tel. No.    |   |
| Support Worker:    |   | Service:    |   | Tel. No.    |   |

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|  **GP details (mandatory):**  |
| GP/Doctors name:  |   |
| Surgery address:  |   |
| Surgery Tel No:  |   |
| Medication details (if any):  |   |

**Has young person recently been referred to another service or are they currently on any waiting lists for other agencies**?   [ ]  Yes [ ]  No

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| **If yes please give details and name the agencies in the space provided**  |
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| **Does young person have any of the following?** Please be advised if you tick any of the below, we will be in contact to source more information  |
|  [ ]  | Diagnosis of ASD  |
|  [ ]  | Learning disability   |
|  [ ]  | Hidden disability e.g. chronic pain or fatigue; head or brain injuries; hearing impairments or vision disabilities  |
|  [ ]  | Mental health diagnosis e.g.  BPD/depression/anxiety  |
|[ ]  Eating disorder |
|[ ]  Physical disability e.g. mobility impairment, (this information is to inform us of accessibility requirements)  |
|  [ ]  | Other  |
|  [ ]  | None of the above  |

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| **Please give additional details on above:**  |
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| **Please check box below indicating referrals Ethnic/Cultural background (using the Irish Census, 2016 categories):** |
|[ ]  White Irish |[ ]  White Irish Traveller |[ ]  Any other White Background |
|[ ]  Black or Black Irish:  |[ ]  African |[ ]  Any other Black Background |
|[ ]  Asian or Asian Irish: |[ ]  Chinese |[ ]  Any other Asian Background |
|[ ]  Roma |[ ]  Other including mixed Background  |

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| **Reason for referral & expectations: How would young person like to benefit from counselling? Please give details of support young person would like in what areas/issues?** |
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| **Expectations of Referrer: How would you like young person to benefit from Counselling?**  |
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| **Expectations of Family, Parent/Guardian where applicable** |
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| **Please provide any additional information that may be of support to this referral?** |
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**Please tick box for declaration below**

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| **Declaration: I** **confirm that the information provided above is true and accurate to the best of my knowledge**  |  [ ]   |

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| **Signed by Agency Referrer**\*Type name if filling in online  | **\***  | **Print name:**  | **\***  |
| **Date:**  |   |   |   |

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

All referral forms to be emailed to: 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