# Limerick Youth Service – Be Well Team Agency Referral Form

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | |  | |  |  |  |

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

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Gender:** |  | Female |  | Male |  | Other |  | Prefer not to say |
| **Nationality:** |  | Irish |  | Other |
|  |  |  |  |  |

|  |
| --- |
| **If other, please give details** |
|  |

**Is Young person being referred attending secondary school?** (Please check or tick appropriate box below)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

|  |
| --- |
| **If yes, please provide a school name and brief address:** |
|  |

**Education & employment status** **of young person**

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

|  |  |
| --- | --- |
|  | 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 |

|  |
| --- |
| **Please give additional details on above:** |
|  |
|  |
|  |

**Family Contact Details**

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

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

|  |
| --- |
| **Emergency Contact details if different from above:** |
|  |
|  |
|  |

**Sensitive Personal Details of young person:**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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. |  |

|  |  |
| --- | --- |
| **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

|  |
| --- |
| **If yes please give details and name the agencies in the space provided** |
|  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| **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 |

|  |
| --- |
| **Please give additional details on above:** |
|  |
|  |
|  |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 | | |

|  |
| --- |
| **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?** |
|  |
|  |
|  |
| **Expectations of Referrer: How would you like young person to benefit from Counselling?** |
|  |
|  |
|  |
| **Expectations of Family, Parent/Guardian where applicable** |
|  |
|  |
|  |
| **Please provide any additional information that may be of support to this referral?** |
|  |
|  |
|  |

**Please tick box for declaration below**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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](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