# 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 if applicable, 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 3rd Level 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: |  |
| Medical conditions / medication details (if any): |  |

Note: Please provide details about any medical conditions that may affect the individual's participation in our program. This includes, but is not limited to, information about anaphylactic shock, physical conditions, and insulin dependence. If the individual is currently taking any medications, please ensure to fill in the field above.

**In the event of an accident / illness requiring emergency treatment and failure to make contact with any of the persons listed on this form, I agree to give consent to the administration of treatment from a qualified medical practitioner.**

Yes  No

**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?**  **ONLY tick if official diagnosis present.**  In cases of ASD/ADHD, please indicate if waiting for official assessment.  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 |
|  | Substance misuse (Please note in case of addiction, we may discuss support from agency such as CSMT, HSE drug and alcohol services) |
|  | 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 the support young person would like, including the areas or issues they need assistance with.** |
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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](mailto:bewellteam@limerickyouthservice.org) or posted to: Be Well Team, Limerick Youth Service, 5 Lower Glentworth St., Limerick V94 YF95

Any queries, please phone Siobhan O’Brien on 0863895031