**Referral Form**



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| Part 1: Notification | | | | | | | |
| Young Person’s details | | | | | | | |
| Last name: |  | First names: | | |  | | |
| Current Address. |  | Home Address (If different from current address.) | | |  | | |
| Date of Birth |  | Medical Card No. | | |  | | |
| Ethnicity: |  | Gender: | | |  | | |
| Nationality: |  | Language: | | |  | | |
| Immigration status: If applicable |  | PPS. number: | | |  | | |
| Care/legal status (If applicable.) | |  | | | | | |
| Has the young person a disability? | | | YES |  | | NO |  |
| Further details of above, if any: | | | | | | | |

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| **Referring authority details** | |
| Referring/responsible authority: |  |
| Care Manager: |  |
| Address: |  |
| Telephone number: |  |
| Social Worker/Aftercare Worker: |  |
| Address: |  |
| Telephone number: |  |
| Out of hours service contact: |  |

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| **Current/ Previous Placement Intervention details. (If Applicable)** | | |
| Placed with: (establishment/ organisation) |  | |
| Date(s) of placement(s) |  | |
| Is the move (If moving from out of home placement) | Planned | Unplanned |
| Anticipated end date/duration of intervention: |  | |

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| **Request for Support from B.H.C.** | | | | | |
| Level of urgency re. referral | | | | High  Low | |
| Is the client aware a referral has been made? | | | | Yes  No | |
| Is the family aware a referral has been made? | | | | Yes  No | |
| Staff required: **Male Female Either** | | | | | |
| Number of staff per shift (1:1, 2:1 etc.): | | | | | |
| Type of service requested |  | | | | |
| Proposed period of engagement | **Start date:** |  | **End date:** | |  |
| **Special needs of young person:**  *(Please include current presenting issues, areas of concern, priority issues to be addressed, strengths, weaknesses. Please indicate assessed level of ability regarding self-care)* | | | | | |
| **Overview of client key risks:** (Please include risk to self and others)   |  |  |  |  | | --- | --- | --- | --- | | **Risk** | **Low** | **Medium** | **High** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **N**OTE: a full risk assessment will be required prior to a referral being accepted | | | | | |

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| **Service requested** |
| **Details of service requested**  *Please indicate proposed level of support required;* ***include*** *arrangements for plan reviews, date service requested to start, and expected duration/end date, and specific outcomes required.* |
| **Financial arrangements/support** |
| **Any other information**  ***Please include*** *significant relationships, parents, siblings, and children, and who has parental responsibility if young person is under 18* |
| **Placement plan, risk assessment & information sharing** |

***Please attach a copy of the young person’s current plan, risk assessment and information sharing agreement to this referral form.***

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| Review Dates / Proposed Methodology |  | | | | |
| **Referring Worker:** |  | **Signature:** |  | **Date** |  |
| **Referring Manager** |  | **Signature** |  | **Date** |  |

**Please return completed form to:**

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| **Please return the completed form to:**  [naomi.s@barroghealthcare.ie](mailto:naomi.s@barroghealthcare.ie)  ***All of the above email addresses are secure/encrypted.*** |