



YOUNG PERSONS PERSONAL DETAILS		
Name of Young Person:		
Date of birth:	Gender:	Ethnicity:
Address:		
School:		Class/ Year:
Young person's hobbies/ interests:		
PARENT/ GUARDIANS DETAILS		
Name of Parent/ Guardians:		
Address of Parent/ Guardian:		
Relationship to young person:		Contact number:
What outcomes would you like the young person to achieve as a result of attending this service?		
Any Other Relevant Information: e.g. recent significant events, medical, other agencies involved (current or past)		
Has the young person been referred to any other service? (CAMHS, Community Psychology, Social Work)		
This service is funded through Community Foundation of Ireland on behalf of RTE Toy Show Appeal.		



Adolescence Counselling Service for Leitrim

Have the parents/ guardian given consent for this referral?	
Has the young person been informed about this referral?	

Parental Consent	Signature	Date
Parent 1 Signature		
Parent 2 Signature		

REFERRER DETAILS	
Referred by:	Referral Agency:
Contact Number:	Email:
Signed:	Date:
I have read the attachment on the brief intervention service/criteria	YES NO
The referral meets the criteria attached for the service.	YES NO

Mohill, Carigallen and Ballinamore – Angie McKenna , Coordinator, Mohill Family Support Centre.
 Contact: coordinator@mohillfsc.info or 071-9631253