Adolescence Counselling Service for Leitrim

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)		

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 **The referral meets the criteria attached for the service.**	**YES** **NO** **YES** **NO**

There will be a minimum of €20 per session with the counsellor as we are only partially funded for the service and if clients can contribute more this would be much appreciated as this helps for the service to continue. We thankyou in advance for your understanding any issues please contact Angie the Manager

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