KILDARE
supporting U and
your mental health

REFERRAL FORM

Referral from (Agency):

Referrer's Name & Position:

Client's Name:

Client's Signature:

Home Address:

Emergency Contact:

Existing Key Worker:

Does the client have any personal, cognitive or medical issues that may affect their participation in the group? If so, please outline:

PLEASE TURN OVER

Risk factors:

Supportive factors:

Reasons for referral:

I, the referrer, have the consent of the person named above to make this referral:

Signature:

Date:

Yes ◯

No ◯

Note: We will hold the information for the whole purpose of working with you as a participant on the HEADSUP programme and thereafter for future wellness events and training opportunities and support. We hold this information for 3 years - however, if at any stage you wish us to delete your personal information, we will absolutely do this safely, confidentially and securely.

PLEASE POST REFERRAL FORM TO: Deirdre Bigley, HEADSUP Kildare, County Kildare Leader Partnership, Kildare Community Development Centre, Meadow Road, Kildare Town, Co. Kildare. R51 RF88. (MARK 'PRIVATE & CONFIDENTIAL')

OR EMAIL TO: deirdre@countykildarelp.ie

HEADSUP Kildare, County Kildare Leader Partnership, Kildare Community Development Centre, Meadow Road, Kildare Town, Co. Kildare, R51 RF88