



Referral from (Agency):

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Referrer's Name & Position:


Client's Name:

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Client's Signature:


Home Address:

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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:

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Risk factors:

[Redacted area for Risk factors]

Supportive factors:

[Redacted area for Supportive factors]

Reasons for referral:

[Redacted area for Reasons for referral]

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

Signature:

[Redacted area for Signature]

Date:

[Redacted area for 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](mailto:deirdre@countykildarelp.ie)

