

# REFERRAL FORM

## Willow Grove Adolescent Mental Health Services



Please Complete **All** Sections and Return the Referral Form by Post / Fax  
To the Adolescent Mental Health Services Team @

- The Dean Clinic, Old Lucan Road, Co Dublin **Tel: 016515212 Fax: 016217978**
- Willow Grove Adolescent Unit, St Patricks University Hospital, James's Street, Dublin 8  
**Tel: 01 2493687 / 01 2493690 Fax: 01 2493580**

### Young Person's Details

FULL NAME: (please print)		
MALE/FEMALE:	DATE OF BIRTH: (dd/mm/yy)	CURRENT AGE:
MARITAL STATUS:	ETHNIC GROUP:	1 <sup>ST</sup> LANGUAGE
PATIENTS ADDRESS:		
SCHOOL  Is the young person currently attending school? Yes / No		SCHOOL YEAR
DOES THE YOUNG PERSON HAVE A RECOGNISED DISABILITY?		

### Referrer's Details

TODAYS DATE: (dd/mm/yy)	Contact Address:
Name of Referrer:	
Contact Phone Number:	
Contact Fax Number:	
Email Address:	

### Parent's / Guardian's Details

NAME:	CONTACT ADDRESS:
CONTACT PHONE NUMBER:	
NAME:	CONTACT ADDRESS:
CONTACT PHONE NUMBER:	

## Reason for Referral

*If Needed Please Include Additional Information On Separate Pages*

RISK TO SELF:
RISK TO OTHERS:
PAST PSYCHIATRIC HISTORY(PLEASE INCLUDE ALL CORESPONDENCE)
PAST MEDICAL HISTORY: Include Any Known Allergies - Has a medical examination recently been carried out? - Date & Outcome?
FAMILY / SOCIAL HISTORY:
MEDICATIONS:
FORENSIC HISTORY / SUBSTANCE MISUSE:

Any Referral's to (past / present) <i>Please Tick</i>	Current Services Involved <i>Please Tick</i>
Social Services? / In Care?	Social Work? / In Care?
Other mental health services?	Paediatrician?
Other psychology services?	Community Psychology?
This service previously?	Speech and Language Therapy?
Any Other?	Autism Services?
	Any Other?

Has Parental / Guardian consent been given? <i>Please Tick</i>	
Both Parents/Guardians	Neither
One Parent (Father)	One Parent (Mother)

* PLEASE NOTE THAT THERE IS AN ATTENDANCE FEE AT THE ASSESSMENT CLINICS		
Health Insurance? YES / NO	Name of Insurer:	Policy Number:
"I understand that I retain clinical responsibility for this patient until they are seen at the assessment clinics" Both Referrer and Patient will receive confirmation of the appointment.		
Signed:		
Name (Block Letters)	Date:	