

TURAS COUNSELLING SERVICES LTD - REFERRAL FORM

In order to provide you with the best service, referral information will be shared within Turas Counselling Services Ltd. This is to ensure your needs are met within the most appropriate service. If you have any concerns, or would like to discuss your needs further please contact Turas on the numbers overleaf.

Name:	D.O.B & Age:	Gender:
Referral Date:	PPS NO:	Referral Source:
Address & contact details:	Address: Mobile: _____ Land line: _____ Email: Can we contact you in writing, by phone or email? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please advise the best means of contact:	
Reason for referral:	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit drugs <input type="checkbox"/> Licit drugs <input type="checkbox"/> Other problem How long has drinking and/or drug use been a problem (weeks/months/years): _____ _____	
Services sought:	<input type="checkbox"/> Counselling <input type="checkbox"/> Community Alcohol Detox* <input type="checkbox"/> Outreach Support** <input type="checkbox"/> Structured Day Programme <input type="checkbox"/> Six Week Motivational Programme <input type="checkbox"/> Men's Smart Recovery Group What would you like to get from this service: _____ _____ <small>*If self-referral/agency referral for community alcohol detox (CAD) – a referral is also required from the individuals GP. Turas can instigate this process but require the individuals GP details. ** Turas provides an outreach service for adults at specific locations in Dundalk. Turas also provides an outreach service for 14-17 year olds in The House, Cox's and the Redeemer Family Resource Centre, Dundalk on specific days, to avail of this outreach service parental consent maybe required.</small>	
Are you registered with a GP? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please provide details)		
GP Name:		
Address and phone contact:		
Please list any medications and reasons for taking them:		

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Does the Individual/Service user give consent for Turas to contact and share information with their GP as part of the CAD assessment?

Yes No Individuals signature: _____

If you are under 18 is your parent/guardian aware you are making this self-referral: Yes No

Other Agency support:

Address:

Phone:

Referrer details: (if you are completing this form for yourself you don't need to fill in this section)

Agency:

Address:

Named person and contact details:

Is the Individual/Service User aware of the referral: Yes No

If the referral is for a young person aged 14-18
has parental consent be obtained: Yes No

If no, please advise why this is the case:

Are there any risks that we should be aware of? Yes No

If yes please provide details (e.g. alcohol/substance related, mental health, suicide/self-harm, risk from others, child protection)

Can we use your premises to conduct appointments with this person? Yes No

Would you like feedback on the outcome of this referral? Yes No

How did you hear about the service? _____

Please send this referral form to:

A: Turas Counselling Services Ltd, 59 Clanbrassil Street, Dundalk, Co Louth

E: info@turascounselling.ie , T: 042 933 8221/4 , F: 042 933 8225

W: www.turascounselling.ie