|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Details** | | | |
| **NAME:** |  | | |
| **ADDRESS:**    **POSTCODE:** |  | | |
| **DATE OF BIRTH:** |  | | |
| **TELEPHONE NUMBER:** |  | | |
| **EMAIL ADDRESS:** |  | | |
| **INTERESTED IN:**  **(Please tick one box)** | Services for people with mental health problems | Services for  people with disabilities | Services for  people 50+ |
| **GP AND SURGERY NAME:** | |  | |
|  | |  | |
|  | |  | |

**What outcomes are you hoping for?**

**Any additional information:**

**Reduced social isolation**

**Reduce reliance on HSE services**

**Build relationships in the local community**

**Improve confidence and self esteem**

**Other (please state)**

**………………………………………………………………..**

**Risk Information**

This information should be filled in by the referrer.   
Please inform us if there are any past and/or present issues in the following areas that we may need to be aware of regarding the client’s welfare.

**Are you aware of any possible risk to the person themselves, or to others, that we should also be aware of?**

**Name of person requesting referral: Job title:**

**Contact Number: Date:**

**Please Return this form to Social Prescription Co-ordinator** [**oldervoiceskildare@gmail.com**](mailto:oldervoiceskildare@gmail.com)

**Or for more information or queries, contact Denise Croke on 0871411669**