

Youth Work Ireland Galway
197 Castle Park, Galway
091-561637

**YOUTH COUNSELLING SERVICE FROM SEP 2026
2026/2027 COUNSELLING REFERRAL FORM**

CLIENT INFORMATION:

Name: _____ Date of Birth: _____

Gender: _____ Pro-nouns: (eg. She/her, he/him, they them) _____

PARENT/GUARDIAN INFORMATION:

Name of Parent(s) _____

Or

Guardian: _____

Address: _____

Phone no: _____ Email Address _____

Is the young person/parents aware of the referral? Yes No

REASONS FOR REFERRAL (PRESENTING PROBLEMS):

REFERRING PROFESSIONAL INFORMATION

Name of Referring Professional: _____

Address: _____

E-mail: _____

By signing below, I consent for the personal information contained on this form to be used only for the purpose it is given. I understand that this information will be stored securely by the Youth Counselling Service within Youth Work Ireland Galway.

A copy of Youth Work Ireland Galway's Data Protection Privacy Policy is available on request or on www.youthworkgalway.ie

Signed: _____ Date: _____

**Please return this form to: Aisling Dermody, Youth Counselling Service, Youth Work Ireland Galway,
197 Castle Park, Galway.
aisling.dermody@youthworkgalway.ie**

For office use only: Reference number: _____
--