

REFERRAL FORM
YOUTH COUNSELLING SERVICE
Appointments 2026/2027

CLIENT INFORMATION

Name: _____

Date of birth: _____

Gender: _____

Preferred pronouns: _____

PARENT/GUARDIAN INFORMATION (IF UNDER 18)

Parent/Guardian 1

Parent/Guardian 2

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Email: _____

Email: _____

Is the young person / young adult aware of the referral? Yes ☐ No ☐

Under 18s: is the parent/guardian aware of the referral and the issues? Yes ☐ No ☐

REASONS FOR REFERRAL (PRESENTING ISSUES)

REFERRING PROFESSIONAL INFORMATION

Name of referring professional:

Job title:

Organisation:

Email:

Phone number:

CONSENT

Please tick each box to give your consent. Consent must be actively given by ticking — a signature alone is not sufficient.

- ☐ I consent to the personal information contained on this form being used only for the purpose for which 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 at www.youthworkgalway.ie.

Signed:

Date:

Please return this form to: Youth Counselling Service,

**Youth Work Ireland Galway,
197 Castle Park, Ballybane, Galway
H91A7X4**

**Contact number: 087 1209425
counselling@youthworkgalway.ie**

Please mark your envelope or email subject line "CONFIDENTIAL".

For office use only — Reference number:
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