Confidential

Sligo Springboard Family Support Service
2 Racecourse View, Cranmore, Sligo.
Tel: 071 914 7070 Email: info@sligospringboard.ie

Referral Form

Family Name: _____

Are you referring a child/ren, parent or family to our service? **Child/ren** ☐ **Parent** ☐ **Family** ☐

First name: **Mother**: _____ **Father:** _____

Address: _____

Phone number: _____ _____

Language spoken in the home:_____

Children's name(s), date of birth and age(s), pre-/school attendance:

Name	**Date of birth**	**Age**	**Attends what pre-/school?**

Are there child protection concerns?	**Yes** ☐	**No** ☐	**Unknown** ☐

Please give details of any other agency working alongside this Family	
Agency Name:	**Contact Name and Details:**

Which of the following programmes and services are relevant to this referral?	
Early Learning and Care (Sessional Crèche)	
School Aged Childcare (Breakfast Club, School Bus, Homework Support)	
Individual Support for Children and Young People	
Individual Support for Parents	
Meitheal	
Non-Violent Resistance	
Parenting Support (Parent's Plus Programmes)	

What does this person/family most need from us at Sligo Springboard Family Support Service?
1
2
3

4
5

Please provide any other relevant information on the person/family i.e. previous interventions, family background (attach additional pages where necessary)

_____

_____

_____

Please indicate level of need according to the Hardiker Model (see description below)	1	2	3	4

Level 1 Universal - Universal services and community development available to all children

Level 2 Additional - Support services for children and families in need

Level 3 Complex - Services for children and families with serious difficulties

Level 4 Acute - Intensive long-term support and rehabilitation for children and families

Please confirm that you have discussed this referral with the parent/family.	**Yes ☐**	**No ☐**
Have you received their consent to refer them to our service?	**Yes ☐**	**No ☐**

Please complete either Part 1 or Part 2 below:

Part 1: **Contact Details for Referring Agency**	**Relationship to person(s) being referred**	
Agency Name and Address:		
Contact Person and Profession:		
Contact Details: **Phone:** **Email:**		
Part 2: **Is this a self-referral?**	**Yes ☐**	**No ☐**
Is this a referral for a family member? **If so, please provide your details below:** **Name:** **Relationship to Family:** **Phone:**	**Yes ☐**	**No ☐**

Signed: _____ **Date:** _____

Thank you. We will contact you shortly regarding this referral

Administration Only:		
Received By:		
Date of Receipt:		
Acknowledged by:		
Date of Acknowledgement:		
Allocated to:		
Date of Allocation:		
Referral Status	**Accepted ☐**	**Not Accepted ☐**
Agreed date for intake meeting		