Confidential

Sligo Springboard Family Support Service

2 Racecourse View, Cranmore, Sligo / Tel: 071 914 7070

Referral Form

Are you referring a child/ren, parent(s)/Guardian(s), or an individual adult to our service?

Child/ren ☐ Parents/Guardian(s) ☐ Individual Adult ☐

Family Name: _____

First name(s) of referred party: _____

If applicable: 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 ☐**	
Are the family open to Social Work?	**Yes ☐**	**No ☐**	**Previously open ☐**	**Unknown ☐**

Please give details of any other agency involved:	
Agency Name:	**Contact Name and Details:**

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

What does the referred party most need from us at Sligo Springboard Family Support Service?
1
2
3

4
5

Please provide any other relevant information on the referred party 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/individual adult.	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 of Referring Agency**	**Relationship to person(s) being referred**	
Agency Name:		
Contact Person and Profession:		
Phone: **Email:** **Address:**		
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 member:** **Phone:**	Yes ☐	No ☐

Signed: _____ **Date:** _____

Please send completed Referral Forms by email to john@sligospringboard.ie or by post to Project Manager, Sligo Springboard Family Support Service, 2 Racecourse View, Cranmore, Sligo.

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		