

## Professional Request for Services

### *PRIVATE AND CONFIDENTIAL*

Family Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone/Mobile: \_\_\_\_\_

Name of Child/Young Person referred: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Please give details of other family members:

Name	D.O.B.	School/Employment	Relationship to child/ young person referred

Referring Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone/Mobile: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

\_\_\_\_\_

Family history/relevant background: \_\_\_\_\_

\_\_\_\_\_

Please state any significant events which have occurred within the family: \_\_\_\_\_

\_\_\_\_\_

Name of Family GP \_\_\_\_\_

Contact address/telephone/mobile number of Family GP: \_\_\_\_\_

\_\_\_\_\_

Name of Consultant/Community Paediatrician/Psychiatrist/Psychologist involved: \_\_\_\_\_

\_\_\_\_\_

Any other pending assessments: YES/NO  
Is the young person currently involved in other forms of intervention? YES/NO  
If YES, please specify \_\_\_\_\_  
\_\_\_\_\_

Medication: please state type and dosage levels (*If applicable*): \_\_\_\_\_  
\_\_\_\_\_

Social work contact with family, if any: \_\_\_\_\_  
\_\_\_\_\_

Profile of young person  
(social, emotional, physical & educational development, interests or peer relationships):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Young Person's view of referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family's view of referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Problems as seen by the family (please ensure that this section is discussed with the family prior to completion): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Safety/risk factors (for client and others): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any considerations to race, religion, language and culture: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Practical considerations (such as disability, significant dates etc): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you hope to achieve in making this referral to NI-ADD?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other information you feel is relevant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Professional: \_\_\_\_\_  
Position: \_\_\_\_\_ Date: \_\_\_\_\_

**Please forward this form and any reports/documents relating to the referral to the following address:**

NI-ADD Children's Charity  
71 Eglantine Avenue  
Belfast BT9 3EW

If you require any further information please feel free to contact NI-ADD on **028 90 200110**

Please note that NI-ADD hold client information on a confidential database in accordance with the 1998 Data Protection Act.

Please complete all aspects of this form as incomplete applications may be rejected.