



Children's Charity
Northern Ireland-Attention Deficit & Hyperactivity Disorder

Self Referral

PRIVATE AND CONFIDENTIAL

Name: _____

Address: _____

Telephone/Mobile: _____

Occupation: _____

Work Telephone: _____

Please tell us about the members of your family:

Name	School/Employment	Date of Birth

Reason for referral: _____

Family history: _____

Have there been any major events which have occurred within the family? _____

Please detail input from other Professionals/Agencies to avoid duplication of services:

Please specify the area of services you require by ticking the appropriate boxes below.

(Please note: a maximum of only 2 boxes should be ticked):

NI-ADD's Parenting Programme: <i>Please indicate preference of either morning or evening programme:</i>	Group Work	Individual Counselling <i>(For Adults and Adolescents)</i>
10.30am-12.30pm <input type="checkbox"/>	7-9 Years <input type="checkbox"/>	Art Therapy <input type="checkbox"/>
6.30pm-8.30pm <input type="checkbox"/>	10-12 Years <input type="checkbox"/>	Sibling Group <input type="checkbox"/>
	13-15 Years <input type="checkbox"/>	
	16+ <input type="checkbox"/>	

Name of Emergency Contact: _____

Address: _____

Telephone/Mobile: _____

Signature of Person Requesting Referral: _____ Date: _____

Signature of Parent/Guardian (*If applicable*): _____ Date: _____

Please forward this form 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 us 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.