Support
Treatment
Aftercare
Rehabilitation

BALLYFERMOT STAR

Referral form for B.A.R.K. (Ballyfermot Aftercare Recovery Klub)

Date of Referral:	
Name:	
Address:	
Phone:	**D.O.B:**
Self- Referral	**Yes[ ] No[ ]**
Concerned Person/Family member	**Yes[ ] No[ ]**
Referrer Name:	**Organization:**
Address:	
Phone:	**Email:**
Is participant aware of referral	**Yes[ ] No[ ]**

Consent

I/the participant consents to having personal data processed and stored by Ballyfermot STAR CLG for the purposes of providing the service requested. ☐ (Please tick box to confirm)

I, _____ (please print name) give Ballyfermot STAR CLG permission to communicate with the above-named referrer about the progress of this referral. _____ (Participants signature).

Nb* – No information will be communicated about the referral without the permission of the participant.

In the event we are unable to make contact all data stored will be deleted in rotation.

Section B – Medical Information

Current status of Participant	On Methadone Maintenance	Prescribed Benzodiazepines	Alcohol	Other Medication	Drug free
Duration of present stability	3 months	6 months	9 months	12 months	Longer

Other relevant information _____

_____

Office Use

Contact 1 - ___/___/_____ by text/phone/through referrer by _____ Contact made – Y / N
Contact 2 - ___/___/_____ by text/phone/through referrer by _____ Contact made – Y / N
Contact 3 - ___/___/_____ by text/phone/through referrer by _____ Contact made – Y / N

Assessment 1 - ___/___/_____ With _____ Attended – Y / N
Assessment 2 - ___/___/_____ With _____ Attended – Y / N
Assessment 3 - ___/___/_____ With _____ Attended – Y / N

(Vers. July 2022)

Please email all referrals to: aftercare@ballyfermotsar.ie Any queries regarding referral contact: 0876549437