Support
Treatment
Aftercare
Rehabilitation

BALLYFERMOT STAR

Community Referral form Ballyfermot STAR CLG

Referring to :			**REALT SOLAS**					

DATE OF REFERRAL:_____ **CLIENT NAME:**_____**DOB**_____

PHONE:_____ **ADDRESS:**_____

Referrers Name: _____Organization: _____

Address: _____Phone: _____Email: _____

Reason for Referral ?

_____

_____

_____

What is the person understanding of their support needs ?

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Please fill out the form completely and return it to the Ballyfermot STAR CLG office in a sealed envelope with the appropriate service name. Alternatively you can email shaydonnelly@ballyfermotstar.ie with the title Referral for and the Service Name in the subject line.

For any questions or additional information, contact us at:

Phone 01-6238002

Email info@ballyfermotstar.ie

For more information on the services we provide at Ballyfermot STAR, please visit our website at ballyfermotstar.ie

Thank you for your referral Ballyfermot STAR CLG , we are dedicated to supporting recovery and personal growth.

Consent

I/the client 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. _____ (Client signature).

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

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

Please note All childcare applications where the parent is not linked with a community treatment service should be submitted directly through REALT BEAG. For the purpose of this application, please provide only the contact information of the parent. Our childcare staff will follow up accordingly.

Thank you .